DOCUMENT RESUME

ED 053 285 VT 011 201

AUTHOR	Kimbrough, L. S.
TITLE	Physicians in Residence Program. Final Report, Supplemental Report, and Conference.
INSTITUTION	California Univ., San Francisco. Medical Center.
SPONS AGENCY	Public Health Service (DHEW), Washington, D.C. Bureau of Health Manpower.
PUB DATE	69
NOTE	355p.
EDRS PRICE	EDRS Price MF-$0.65 HC-$13.16
DESCRIPTORS	Conferences, Educational Programs, *Evaluation, *Hospital Personnel, Hospitals, *Medical Schools, *Physicians, Records (Forms), *Refresher Courses
IDENTIFIERS	*Physicians in Residence, PIR, University of California

ABSTRACT

The Physicians-in-Residence (PIR) Program was developed for 14 hospitals in Northern and Central California communities and in Reno, Nevada, to establish continuing education programs for practicing physicians in local communities. The hospitals were selected, the most urgent needs of the medical staff of each hospital were identified, and members of the medical faculty from the University of California were selected to teach at 3-day meetings at each of the hospitals. Following the visit, each PIR made a detailed report to the project director. At the end of the program, a conference between the Continuing Education Staff, participating faculty, and representatives of the community hospitals was held to discuss the impact and effectiveness of the educational program. The local hospitals were unanimous in their desire to maintain and extend the program. In some instances, patient care had improved, and new facilities not previously contemplated had been planned. The medical school faculty indicated that their experience in the community hospitals might modify their approach to medical students. Lists of physicians, hospitals, and an evaluation of the conference proceedings are included. (BC)

130

ED053285

PHYSICIANS-IN-RESIDENCE
EVALUATION CONFERENCE

Crystal Ballroom
San Franciscan Hotel
January 25, 1969

7

Reported by:
PAUL SCHILLER

VT011201

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

The PHYSICIANS-IN-RESIDENCE EVALUATION CONFERENCE was called to order on Saturday, January 25 1969 at 9:15 a.m., in the Crystal Ballroom of the San Franciscan Hotel, in San Francisco, California.

The following transcript of the Conference has been minimally edited with two purposes in mind: (1) retain the substantive issues raised by principal speakers and discussants and (2) preserve the sense of spontaneity and free exchange of ideas which characterized the Evaluation Conference.

I. Introductory Remarks by Dean Stuart Cullen Dean of the School of Medicine University of California San Francisco Medical Center.

II. Remarks by Dr. Allan S. Kaplan, Bureau of Health Professions Education and Manpower Training, NIH&A.
Report on P-I-R program at REDDING, CALIF., by Mr. Robert A. Roberts Administrator of Memorial Hospital, Redding.

III. Report on MARYSVILLE-YUBA CITY, CALIF., by Dr. Joseph A. Salopek, Chief of Staff Marysville-Yuba General Hospital.

IV. Report on SALINAS-MONTEREY, CALIF., by Dr. Carl J. Leonard, Director of Medical Education Salinas General Hospital.

V. Report on SAN LUIS OBISPO, CALIF., (letter from) Dr. Richard Anderegg, Director of Medical Education San Luis Obispo General Hospital.

VI. Report on CHICO, CALIF., by Dr. Carlton Huitt, Chairman of the Program Committee, Enloe Memorial Hospital.

VII. Report on MERCED, CALIF., by Dr. John D. MacCarthy Chairman of the Program Committee, Merced General Hospital.

VIII. Report on EXETER, CALIF., by Dr. Ward Evans Chief of Staff, Exeter Memorial Hospital.

IX. Report on TULARE COUNTY, CALIF., by Dr. Eugene Bifulco Chief of Staff Tulare County General Hospital.

X. Report on WATSONVILLE, CALIF., by Dr. David E. Bushman, Director of Medical Education, Watsonville Community Hospital.

XI. Report on UKIAH, CALIF. by Dr. Frank H. Leeds (P-I-R).

XII. Report on MODESTO, CALIF., (letter from) Dr. William A. Todd, Jr. Assistant Director of Medical Services Scenic General Hospital

XIII. Report on RENO, NEVADA, by Dr. Robert J. Barnet Chairman of the Program Committee, Washoe Medical Center.

XIV. Report on STOCKTON, CALIF., by Dr. Victor Richards (P-I-R).

XV. OPEN FORUM DISCUSSION

MODERATOR DR. KIMBROUGH: Gentlemen I think we will begin our business for the day ... I want to personally welcome you here ... We will have some welcoming remarks by Dean Stuart Cullen, Dean of the School of Medicine here at the University of California in San Francisco.

DEAN STUART C. CULLEN: Thank you, Dr. Kimbrough. I do welcome you personally and on behalf of the School of Medicine.

I am personally enthused from the standpoint of what this program can do for the School of Medicine and, of course what it can do for you. I think it is an innovative idea and worthy of pursuit and exploitation.

I think in part I lean this way toward this type of program because I have had some experience in the past working for the World Health Organization and the Unitarian Service Organization on trips to Europe as part of medical missions, and I have been impressed since that time with the advisability and the usefulness and the productivity of putting a teacher into the community in which the practice actually exists.

Continuing Education puts on some wonderful courses here on campus and these serve a very useful purpose but there is another useful and productive educational effort that can be done by bringing the teacher into the community where the problems exists and where one can relate the educational effort to the actual practice right on site. This is important to the school because ... I am anxious to have much more contact than we have had in the past with the practicing physicians of the state, and particularly Northern California ...

Although we actually never did, we no longer can we stay in some sort of pristine isolationism on this mountain over here. All the interest, all the effort these days is getting out into the community and this is a prime obligation of the Schools of Medicine. We can do that only if we have the sort of contacts that develop through other programs and especially this one, and I am particularly anxious to develop those contacts.

These contacts are important, because not only of the educational value to the practicing physicians out in the community, but the feedback to the institution. If the institution is aware of what is going on in the practice of medicine then we can do a better job I think, of educating our medical students in what they need to know to become top-flight practicing physicians. This feedback process is in both directions, and I think it is exceedingly important.

The teaching of medicine has to be related to the community...this is a factor that is recognized nationally and by...those of you who are familiar with the Regional Medical Program who know there has to be an identification with the community. Those of you who are familiar with the Comprehensive Health Planning Program know that the law specifically states that there have to be consumer representatives on the committees.

I happen to be on the Health Manpower Council and it has to have other representatives of the consumer. Only last week I attended a conference sponsored, in his last gasp effort, by Wilbur Cohen at the Jack Tar Hotel about the cost of health care. Here again the community is represented, so that there is no question about what is happening in the matter of health care education and its delivery. You people are important in this program and this program is important in fostering, exploiting and developing that concept.

We are making efforts to move out into the community as far as the school is concerned. We have affiliations with either hospitals in this community now, plus one in Santa Rosa. We are sending 30 students for their core instruction in obstetrics and gynecology...and 30 in general surgery... to Childrens' Hospital. For what used to be called the old physical diagnosis course in the second year, we used I think a total of about 18 hospitals and 150 instructors and this was done in large part in many of the community hospitals.

Our relationships have already been established and have been in operation for many years for house staff integrative programs, and this is being expanded in some hospitals, so that we are moving out into the community. This is necessary, not only for the reasons I stated before, but because we are just really short of beds.

Fifty-five percent of our teaching both of medical students and of house staff, is done off the campus. This involves San Francisco General Hospital, the Fort Miley Veterans Administration, the Letterman, the Public Health Hospital and also the voluntary community hospitals. We just don't have enough beds now to teach the 128 students we have in each class. We propose to move ahead and increase this class size and are planning now on adding six more students in the fall of this year and to do this we are going to need more patients and more facilities, and we do this in large part by moving into the community. Even if we build additional beds on campus, we would still have to move into the community.

As I indicated, one of the hospitals with which we are related is the Santa Rosa Community Hospital...we are in the process of participating in the education of general practitioners...through this...association with the Santa Rosa Community Hospital, whereby faculty from our place go to Santa Rosa and teach the general practice residents there, and those residents come down to our place for instruction that they cannot receive in their Community Hospital.

...I want to get our faculty in contact with Continuing Education and it in contact with our faculty...you know, that some of our faculty are teaching on patients, that they are in the laboratory...but a good many of them have a good deal to say that I think would be of benefit, and I would like to have you asking for people like Holly Smith in medicine; Rudy Smith, who is an excellent gastroenterologist; Fred Belzer in surgery who is active in the renal transplant program; Samuel Kountz the man who is doing most of the renal transplants; Herb Dedo in laryngology; Sam Aronson in ophthalmology, Mal Powell in nuclear medicine.

...if there is trouble getting some of the faculty moved out into the community let me know and we will lean on it, just a little bit at least...

I think this is sufficient for opening remarks and I don't want to delay your program here, Dr. Kimbrough but I would like to get across to any group such as this, so that they can bring back to the people they talk to the facts, and I think there have been some misconceptions with respect to the action we took in regard to the black students and the black caucus on campus.

Would this be all right, if I mentioned this just briefly?

MODERATOR DR. KIMBROUGH: Yes.

DEAN CULLEN: Because there have been some erroneous ideas, let me say first that the man who had the dogs and was baiting the fuzz and was identified as "Dr. Cleveland" a medical intern at the University of California, is not a medical intern at the University of California. As a matter of fact as far as we can determine he is not an M.D. at all; so if anybody is excited about the fact that we are fostering people in our school who have dogs that bait the fuzz, then just forget it...

Now the black students the black caucus, made what they called 15 demands. A lot of people react to the term "demands." I think one has to be careful not to react. They said "These are demands. These are non-negotiable this is what you have got to do." That is a technique and they were negotiable.

We have fortunately I think good rapport with our students, have had in the past, and this has paid off because we have been able to communicate one with another and arrive at mutually satisfactory solutions...we have held in reserve 32 places for this fall for those students who have for various reasons been unable to get into medical schools before, economic, ethnic, what-not. We are reserving these places until the 31st of May, and then if those places are not filled with these kinds of people, they will be opened up.

We have set up an extension in addition to the regular Admissions Committee and this group will function as a part of the regular Admissions Committee. It is a group that will screen special minority groups, blacks Mexican-Americans and American Indians. We have now, for example as a consequence of the efforts of some of the faculty and of the students particularly, who have gone out and recruited, 59 applications from black Mexican-Americans and two or more from American Indians.

Three years ago we had zero applications from this group and the tendency is always to say "You know we will accept any of these people that apply." The pool is there it has to be sought out. These people have not been applying because they have been told by their counselors in high school their counselors in college, by their friends by their own physicians and what-not, "Don't bother to try to enter medical school. They won't take you in."

Well, the students have gone out to the junior colleges, to the high schools and everywhere and talked to these kinds and said, "You know, at least apply because you have a chance."

We now have 59 applications for this upcoming class this fall, and by a very cursory examination 20 of these can meet the standards of any students that we have ever considered. It is not a matter of lowering standards at all to admit these students. We do not intend to lower standards. These students do not want the standards lowered. They want to come in and compete with the rest on the same basis.

We have had several students as a matter of fact say they did not want to go through the Special Committee; they wanted to go in under exactly the same terms as any other student who has been a member of the school, so we have good rapport, and I think things are going to work and I am very proud, actually of the students that we have and what they have done in the interests of all these people.

If there are questions pertaining to this aspect or any other aspect that I could answer quickly I will try to do so.

Thank you very much, and welcome again.

DR. KIMBROUGH: Thank you, Dean Cullen. At the risk of being called an "Uncle Tom," I shall try to communicate your remarks to the black community.

(informal remarks by Dean Farber not recorded)

* * *

MODERATOR DR. KIMBROUGH: The people responsible for funding our Physicians-In-Residence programs are with us today, Dr. Alan S. Kaplan, Acting Chief, Division of Physician Manpower, Continuing Education Branch of the Bureau of Health Manpower, National Institutes of Health, and Mr. Tucker, Continuing Education Branch, Division of Manpower, Bureau of Health Manpower, both from Arlington, Virginia. . . (also present is) Mrs. Margaret Griffith, Associate Director for Scientific and Educational Activities of the California Medical Association. We would now like to hear from Dr. Kaplan and Mr. Tucker.

Dr. ALAN S. KAPLAN: Thank you very much. It is a pleasure to be here and I hope to learn a lot from you gentlemen.

I might point out that it is the Continuing Education Branch in the Division of Physician Manpower and we have a new name. It was changed to the Bureau of Health Professions Education and Manpower Training, which is now part of the new National Institutes of Health and Administration, and it is part of the new focus of NIH to combine both research and education into a common goal of better health care for people in the United States.

It is our hope that through the work of the Continuing Education Branch we will be able to stimulate and encourage continuing education activities among physicians, with the hope that they will be better able to render care to their patients.

Our prime interest is not so much in putting on programs but in trying new techniques, developing new methods, trying things that have not been done before to see if they can better help get continuing education across to the practicing physician.

In contrast with the Regional Medical Programs, they are more interested at the present time - to my understanding - in content rather than methodology, so I think this creates a very healthy atmosphere in the federal government that we have two agencies working on programs and ideas to improve patient care. Other than that, I would like to sit down and wait and hear what you all have to say, and maybe ask questions later.

MODERATOR DR. KIMBROUGH: Thank you very much. We would like to in discussing the various Physicians-In-Residence programs to ask you to limit each discussion to no longer than 25 minutes.

First of all, I think we should have each of you stand and introduce yourself. We will begin with Dr. Leeds at the end.

(Introduction of participants.)

MODERATOR DR. KIMBROUGH: Now we will hear from Mr. Robert A. Roberts, the Administrator of Memorial Hospital in Redding.

MR. ROBERT A. ROBERTS: Dr. Cullen, Dr. Farber, Dr. Kimbrough, gentlemen: I have a habit of opening my mail regularly and I discovered last night that not only am I supposed to be here, but I am supposed to speak. Our airline from Redding to San Francisco has not been the most reliable, and with this weather Dr. Wells and I got up at five o'clock this morning and drove down, so I composed a few notes enroute.

We may very well be the hospital being the greatest distance from the University and we identify as a community with San Francisco for professional as well as cultural and social things.

Our time of travel by automobile, abiding by the speed laws, is about three hours.

We have been participating in this program for, I believe three years now. It is quite a distance and the men who have come to us the past 12 months have come to us at great inconvenience and sacrifice to themselves, and they have all been top-flight people. We have been delighted to think that 225 miles from the University we can have this sort of assistance.

I will tell you a little bit about Redding. Redding is sort of like Billings, Montana, very few people have gone through but they all heard about it. Shasta County has a population of about 80,000 people. The greater portion of them are in or near Redding. The community of Redding has about 25,000 within its city borders and another 25,000 people in the immediate or adjacent communities, some unincorporated.

The bulk of medicine for the entire county is in Redding. It has developed as somewhat of a medical center for several of our neighboring counties . . . we have almost all of the specialties represented, some rather thinly; however, I think we have just about the works.

Our Medical Society has approximately 100 members, about 70 of those are on the staff of Memorial Hospital. There are approximately 400 acute care beds in Redding at two major hospitals.

We have in the past few years developed some rather sophisticated procedures. We can do just about everything in the way of laboratory, nuclear medicine, x-ray, surgical procedures. Our almost isolation from medical services makes this necessary, and through this demand we just need it. This is one of the areas where continuing education has been so helpful.

I must confess that I think this most recent one, Physicians-In-Residence Program, has been really our very best. It has been very well received. We have been delighted with it, we have had no problems at all securing specified lectures and visitors. We may not always get the person that we asked for, but we have always been very pleased they will send us somebody in that specialty or in that field. We most recently were delighted with an unexpected bonus. Dr. Cullen visited Memorial Hospital a couple of weeks ago and we really do exist up there . . . we have probably 200,000 people to serve . . . so we do have a great deal of contact with the University here and we are quite pleased with the results our patients receive, and the treatment.

Our physicians on our staff have responded very, very well. As a hospital administrator, you do handsprings to tempt these busy practitioners away from their offices and to your hospital or to an auditorium, and it isn't easy. All these men carry full loads, they are very, very busy people. I am sure that is true in all the communities served by this Program, but we have had literally fifty percent in attendance at all of these meetings, and I would say that is a pretty good average.

We are getting not only the same people, which indicates we are communicating with the entire medical staff. We hope that in the coming year we might be able to expand this program to other people in medicine, nursing particularly. We are to have a conference with Dr. Kimbrough soon with respect to that. We would like to expand this entire program to the adjacent hospitals and communities . . . e.g. eastern Shasta County; there is little hospital up there in Fall River Mills that is 70 miles from Redding, so you are coming quite a distance, but I think we can bring them in.

We will soon have a public auditorium built by the city which will be able to accommodate large two and three-day workshops and seminars, and we hope to put that into effect soon.

In talking with many members of the medical staff, I think that they are very pleased with what has been presented, with the warm cooperation that we receive from the Department of Continuing Education. The men that have been sent to us are so very outstanding people, but they are easy to communicate with, they are exceedingly willing to assist in our problems.

I think from the medical staff I gather the greatest value that they have, each one of them personally received, is inspiration, and it is refreshing. We have had cooperation from the Medical Center Library producing literally anything that we have asked for in a Xerox form, sending it up to us, the entire text book, whatever it is that we need. You can imagine that this small community is very, very poor in sophisticated texts, journals, research; it is enormously difficult for local men to find a series of articles on any given subject, and . . . the University has been very accommodating.

Many men on our staff have remarked that through this contact with the University they themselves have been inspired to pursue certain subjects. When they come to the Medical Center they feel that they personally know someone, so they can make a call, arrange to visit the department, or attend a lecture or something that is happening, and I think it is having the effect of bringing our people to the University. Of course, we are delighted with this.

The selfish aspect of this, from our standpoint, is attempting to attract post-graduate students. If we have a connection, we maintain a communication with the staff at the Medical Center and we keep them informed of our needs, and as a matter of fact, they have their eye on one resident that hopefully we will be successful in attracting, one we need very badly. It is one of the specialties that I mentioned earlier that is very thinly represented.

As far as the future is concerned, we want to expand this program . . . with an idea that you all may find an intriguing thought. We have an extremely delicate, technically difficult procedure that our men feel they must acquaint themselves with, and that is the emergency exchange transfusion of new-born. If you can imagine attempting to coordinate a birth of that nature with a visit from a visiting pediatrician from a University, it is next to impossible. And by the same token, it is pretty hard to predict when this will occur at any given time here in San Francisco, so the thought was developed - and I think it is in process now - of doing a video tape or film carefully narrated. Video tape is probably what will be our answer.

The Memorial Hospital is acquiring a unit. We will have one, and we find that all these tapes are not the same. Sony has one, somebody else has another, they are different sizes, but we are going to coordinate our purchase with the Medical Center's Ampex. Thereby we will have the opportunity to run this tape many, many times for small groups on call or at any appointed hour. It is almost self-sufficient as long as one of our people can technically put it in operation, and the staff can have the benefit of this . . . it is not as exciting, I suppose, as our football reruns, but this is an area that I think might well be explored . . .

DR. KAPLAN: You mentioned this Physicians-In-Residence Program inspired you to do something, but I did not get what it inspired you to do.

MR. ROBERTS: It is inspiring to . . . a man working about as hard as he can or thinks he can at least, who neglects to stay up on his reading, and about the only exciting thing is a new pitch from a detail man, and it is a long way to San Francisco . . .

These men from Physicians-In-Residence will quote journals, some recent research, and our staff is asking for these articles, they are being produced for them. Our staff is starting to visit these people in San Francisco that they have met with and discuss special problems.

Each one of our lectures and visitors has given everyone their name through the Administration at the hospital and they encourage our staff and the next time any problem comes up and you have any difficulty with it, they say, "Why don't you give me a call?"

We had a real winner, a new formula for an enema. Actually, it was something that had been apparently used years ago, it is coming on again with excellent results, and about half of the fellows in Redding are using it.

This inspiration is just stepping up their interest in their own education, seeking current knowledge.

DR. KAPLAN: Has there been a documented increase in the use of your library through this program or reproductive servicing?

MR. ROBERTS: I think so. I believe we can document some increased use.

You see in small communities, the County will maintain a legal library but not a medical library, which is frustrating, of course. But it is amazing the libraries that some of the men had in Redding 20 years ago, personal libraries. They felt somewhat isolated, and one fellow probably just felt more secure with a big library. I don't think he used it, but many of these men feel that they can no longer maintain this enormous cost of a current library, even two or three men practicing together. They will have a few books on a given subject and problems for review, but now they feel they are using the hospital library a little more. We have done more with respect to this.

The University of California Library here in San Francisco, I am sure you all recognize, is outstanding in the world, and that has been made available to us and we appreciate it a great deal, and the cooperation and warm response with the people we have been talking to. Anyone at the library has a sincere desire to assist and, by golly, the references they come up with on occasion, they do a remarkable job.

MR. TUCKER: At the beginning, was there any opposition on the part of your staff physicians to the Physicians-In-Residence, in that they felt they were checking on their practice, or anything of that nature?

MR. ROBERTS: No, we did not experience this. There are always people who are insecure . . . but generally our men have just been delighted with this attention actually.

It started out sort of a soft-sell idea. It was a whale of a job getting them to come to our limited facilities. It is a nice conference room but it is nothing remarkable, and to listen to a speaker on the wall (i.e. radio programs). Yet some of the fellows recognizing the problem would secure slides of their own dealing with the same subject.

On occasions where there was a certain examination, you might recall there was one after the program, they all had a question-and-answer sheet and some were reluctant to do that, but they warmed up to it. They do very, very well with the human personage and there is something about face-to-face contact that relieves a lot of tensions.

Questions on the telephone to the studio were at first all taken a little bashfully but here they know the man they are talking to and they can see him.

We started with that and kept doing better. We are unable to achieve television contact at our distance from the broadcast here.

Are there any other questions?

DEAN CULLEN: Two things, one . . . I would like to have you comment whether you think two days, one day, three days . . . is an optimal sort of thing; you might run out of gas talking with each other in three days.

Secondly, just recently I have been importuned by a representative of a television producer, a producer of tapes for the Roach Foundation; and they have tried to get us not to buy - they will deliver it free of charge - tapes that they will send out every month or two months for a week, and I wondered whether you or any of the speakers here would have any interest in the distribution of these tapes.

MR. ROBERTS: Thank you, Dr. Cullen. You bet. This is something we are convinced would work. The thought is that on any given subject, if a tape possibly preceded or was contemporaneous with the visit on any given subject, it would probably be very helpful.

Again, if your hospital is very busy and someone wants to explore the new surgical procedure, it is extremely difficult to have a patient ready to go when the visitor arrives. As a matter of fact, we really have not been able to utilize the surgeon as we should.

As far as our little community is concerned, we have really worked the men from the Physicians-In-Residence very hard.

Here you have a man, he is leaving San Francisco and he is visiting the agency in his day-to-day effort. We invite them to bring their families, we arrange for their accommodations in the most desirable place, in the spring and summer it is mostly near the lake, which is 20 minutes from town. If they want to fly, we see to it that they are provided with transportation. However, if a man is going to drive up, you never can leave on the hour you like to, to the first thing you know he is leaving in the afternoon. He arrives in the evening and, if he has to wrestle with a couple of kids all the way up to Redding, you are ready for a little privacy and relaxation in the evening -- so we try not to put too much of a demand on them in the evening.

The following day we start them off normally at 7:00 a.m. for a breakfast lecture, noon, and a dinner lecture, so we, in between these times, have them see special problems in the hospital and discuss the equipment.

This past visit they reviewed with the architects plans for a new intensive-care unit. I don't think you can get it adequately in one day. Two days would be pushing your man pretty hard, because he has to drive back or fly back.

I am informed that time is running out . . .

MODERATOR DR. KIMBROUGH: Thank you . . . what we would like to have is an appraisal of the accomplishments of the program. Have you seen any instances or can you cite instances of a decrease in morbidity, a decrease in mortality? Have we decreased the cost of medical care in the hospital?

We would like to know whether or not the level of practice in the hospital has been improved as a result of our professor's visit, and then the attitude of the physicians toward continuing education.

We would like for you to limit the opening remarks to ten to twelve minutes, and then we will have an open discussion.

I might just ask Dr. West, as a result of the visit of Dr. Alban and Dr. Cullen, can you cite any decreases in morbidity or infant mortality?

DR. WELLES: The problem, as far as infant mortality as related to exchange transfusions, has only occurred once in the past several years, and it was not a mortality; it was morbidity.

The difficulty is our pediatricians are rather thin in the area, and it is difficult to get men for this emergency procedure. I have not been aware of any further problems with exchange transfusions since Dr. Alban came up. He went over this with us very carefully, so that as a result of Dr. Alban's visit and our request for Dr. Kiyasu, now we feel confident that, should this emergency arise again, which of course, can arise at any time, that any of several men are now able and competent and confident in tackling this emergency procedure, where before we were very skeptical about it.

When Dr. Kimbrough referred to this program, there was the first demand, to have someone come up and lay it down cold for us. It isn't really as formidable a procedure as many of us were afraid it was. Since our first visit from Dr. Alban I have felt much more at ease. As far as I am concerned, I feel very much happier about the situation as a result of these visits.

I might add a little bit that your question was not quite answered, Mr. Tucker, about the reaction of the doctors in the area. Of course, in any area, in any given area, you are going to have some practitioners who are resistant to this type of interference, as they might consider it.

I look back 15 years ago to the circuit-rider programs that we had up there and of which I was Chairman of the County Society committee to arrange this, and the response to those things was absolutely terrible, nil. We had excellent men come up to talk on certain things and would get a turnout of maybe two or three men. It was just embarrassing. So finally I communicated with Dr. Farber by mail and told him to leave Redding off of it, because I did not want to be embarrassed.

Now, the change in these 15 years or so has been remarkable. We went through the period of the radio programs and had fair response. The response of the staff of the medical community now to the visiting professors in residence has been very, very gratifying.

DR. WILSON: Let me ask you one question, sir. You mentioned Dr. Alban, you mentioned Dr. Kiyasu. I believe Dr. Kiyasu's visit was arranged as an additional thing by yourselves?

DR. WELLES: We requested them.

DR. WILSON: It was a result of the program so, if you like, an activity also resulted from it. Would that be correct?

DR. WELLES: That would be right. We really felt the need for this. This is one area where help was very thin, and it has been a remarkable help to us.

MR. ROBERTS: I might amplify, Dr. Kimbrough. Dr. Kiyasu and Dr. Alban were successful on, number one, providing us with a written procedure for this procedure. It is spelled out and we were delighted to get it, and it has been Xeroxed many, many times. . .from the original document.

I think we have had excellent preventive results in three cases being handled properly before there was a problem, and they straightened out the thinking on everyone's part. As, for instance, in this red-hot article in TIME, and it was not as well understood by the men in our community as it should have been and as I believe it is now.

MODERATOR DR. KIMBROUGH: ...We will move on to Dr. Joseph A. Salopek, Chief of Staff at Marysville-Yuba General.

DR. SALOPEK; Dr. Cullen, Dr. Farber, Dr. Kimbrough.

Marysville is about 120 miles from here, north on the way to Redding, and our community consists of two cities, Yuba City and Marysville. Yuba City is in Sutter County and Marysville is in Yuba County...the medical society is called Yuba-Sutter-Colusa Medical Society and there are, I imagine, about 10 or 12 doctors in Colusa who belong to the County Medical Society and many of them attend the County meetings. Two or three of them have attended the Physicians-In-Residence program because it is about 30 miles west, and I think it is a little inconvenient for them to get over.

In Marysville and Yuba City we have two private hospitals, approximately 60 beds apiece. These hospitals as of three days ago were running about 97% occupancy. This may be somewhat unusual because of the flu epidemic with complicating pneumonias we had that necessarily had to be hospitalized but ordinarily they are running at high capacity.

We have two County Hospitals one in Yuba City and one in Marysville. Both of these hospitals, incidentally, are political footballs and there has been a great deal of conflict between the County Medical Society and the County Hospitals.

With me today is Dr. Lee Pieters, who is the Medical Director at the Yuba General Hospital, and since the advent of his assuming the role of Medical Director, things are improving...

The other County Hospital (Marysville) is a closed staff. They have three hired physicians. They have never wanted the Medical Society to have anything to do with the operation of the hospital, so we have left that one alone.

As far as the Physicians-In-Residence program is concerned...for about the past seven months when it was first started...it was under the auspices of the Yuba General Hospital...

The Medical Director of that hospital was not on very good terms with the Medical Society, so the Medical Society were not invited to participate in it by this gentleman, so they were resentful and almost blackballed him. The victim of this was Dr. Blacker who was the first P-I-R speaker to come up there, and it was at this time that I went in as Chief of Staff there, and the other doctor was about to leave and I couldn't stimulate any interest in a week's time.

The Medical Society president told me they were never included in the planning of this program so that they were not going to advertise it at the meeting, although I did get up and advertise it. It did not help very much.

Dr. Blacker spoke mainly to paramedical personnel and a few doctors.

After this period the next P-I-R speaker we had was Dr. Hibbard Williams, and Dr. Williams I think did more to put the program together than anybody. He visited all the hospitals he gave a few lectures he saw patients clinically we had live clinics. He was most accommodating. He went out to the Sutter County Hospital regardless of whether they participated in this program or not and he did a lot for them so that they began to have a different attitude and now they are very enthusiastic about it and just yesterday Dr. Leon Goldman who is here and who has been up in our community for three days was out there and Dr. Goldman also was at the four hospitals.

Dr. Goldman was received tremendously and I think it took a little bit of time because of some misunderstanding because of some resentment that was uncessarily produced by this political football machine that operates the County Hospitals but at the present time I will have to say that it is excellent.

The County Society is enthusiastic about it now and I expect that as time goes by if we have the privilege of having the program continued - which we do certainly want; we really want it - the enthusiasm will continue and increase.

Regarding some of the other questions that you wanted to be briefly answered... Now when Dr. Hibbard Williams and Dr. Goldman were there it was my understanding that this program should include paramedical personnel at least partially. Short periods should be given to them and so when Dr. Hibbard Williams spoke we had announcements to all nurses in the community to four different hospitals and there were about 40 or 50 nurses there and Dr. Williams just as Dr. Goldman did simplified his conversation and simplified his discussion so that they could understand it and they helped the nurses tremendously.

Dr. Goldman I think was very impressed with 40 nurses sitting there the night before last and I don't think any of them stirred. They just listened to him for an hour and fifteen minutes taking notes. All of these nurses were nurses that are taking training in the intensive-care and coronary-care units and they are all I would say enthusiastic in trying to do as much work as they can.

If you go into the intensive-care and you want to start an I.V., they try to push you out of the way. They want to start it themselves. They want to put gas in. They are a very enthusiastic group up there and so I think they benefited by this program too; not only the physicians but the paramedical group.

I think that anybody who leaves medical school and finishes an internship and maybe a residency of a year or so and goes out into general practice in a busy community or rather in a community and he is busy he immediately starts going backwards from the time he starts being busy.

I think that as the years go by there are more and more things that we know less and less about and we can't be specialists in everything. And we can't outside of maybe two or three postgraduate courses a year take any more because we are too tired we are too busy to read at night. We need this and we need more of this type of thing, and I think yesterday when Dr. Goldman got through speaking at the Grand Rounds Meeting there were over 30 doctors there. The general practitioners told me that they very definitely wanted this program; they all feel that they just need something like this. It is really a much more satisfying program for general practitioners than it is for the specialists except the specialists that are in a particular specialty that the individual represents.

We had tremendous response from the surgeons when Dr. Goldman was there. We had tremendous response from the internists when Dr. Williams was there and on both occasions excellent response from the general practitioners.

Just in passing I would like to say in the last seven or eight years there have only been three general practitioners that have come to our community. We have a Medical Society of about 72 members. I think there are many more specialists in Marysville and Yuba City than there are general practitioners and I am very happy to hear you mention that you are training general practitioners and we are trying for them.

There have been two or three that have retired in the last two years and in Marysville right now there are only about four general practitioners. In Yuba City there may be 12 and everyone is just beaten to death with work.

One or two other things regarding the other facets of education: We have not been able to benefit by television because we can't get the reception from San Francisco. There isn't any cable in our community yet so this has not helped us any.

The radio lectures were not very successful. When they first were given they had radio in one of the hospitals and there were several doctors that attended, but each subsequent week there were fewer so that at the end there were just about two or three there and then they stopped it.

The circuit programs I think were somewhat like Redding. The attendance was very poor...

I do think that this program is going to be more and more received. I think it is very necessary and very helpful. I can't tell you about the mobidity or the mortality being affected by it because we have not had it long enough yet but I do know that we have really appreciated it and learned a great deal from it, and I think the physicians in our community are now more or less satisfied that it is an excellent program and they will cooperate tremendously in helping to keep it...

I would also like, if you don't mind to hear from Dr. Pieters. He is here he may wish to say a few words.

MODERATOR DR. KIMBROUGH: Dr. Pieters.

DR. LEE PIETERS: I have practically nothing to add to what Dr. Salopek said. As he did mention this program is just in its infancy up there, actually. There have only been two doctors that I have personally seen Dr. Williams and Dr. Goldman both of whom were - as Dr. Salopek mentioned - extremely well received.

I would echo Dr. Salopek's comments. I think this is a very valuable program education-wise for physicians.

We can't say anything yet as to decreased morbidity and mortality. I know a great deal more about arthritis and renal stones since Dr. Williams' visit. We have had a great increase in the use of the hospital since he arrived there.

Dr. Goldman was up there this past Thursday and Friday. He was very well received particularly by the surgeons. I found it a little embarrassing that a man of his stature and knowledge would come up there for purposes of pointing out things about surgery particularly cases that were presented, and the hospital fed him hot dogs and beans for lunch - but I have no control over the hospital feeding. It won't be that way in the future.

All I can say is that we certainly hope this type of program can continue. It has been a great asset to continuing education.

MODERATOR DR. KIMBROUGH: Perhaps we have a few remarks from Dr. Williams or Dr. Goldman.

DR. HIBBARD WILLIAMS: I want to start off by saying that one of the advantages to going to Yuba and Marysville is the superb walnuts they have there. We are still eating some of the walnuts they gave us up there.

There are four things I wanted to comment on about the program by Dr. Salopek. One is the time. I think it is obvious that the time of a community practicing physician is limited. One cannot go to a community the size of Marysville and Yuba City and expect to spend three days with the practicing physicians. They just don't have the time for it and I think most of us appreciated this, so that perhaps a two-day program as suggested by Dr. Salopek, would be a rational one.

Along with this a talk should be scheduled as mentioned by Mr. Roberts at breakfast, lunch, dinner or in the evening, perhaps allowing separate discussions in the afternoon with paramedical personnel.

The second feature is the fact that I dislike going as the "white knight from the great ivory tower" to bring everything new to Yuba and Marysville. I think this should be a give-and-take exercise, and it was for me. And I would stress the importance of rounding with small groups of physicians rather than a continuing series of lectures. I found this most helpful. It taught me a lot. I learned a lot from Dr. Salopek on going on rounds with him. I think this sort of informal give-and-take about certain patients in a small group is a very valuable one, and I would encourage the use of this type of program.

Finally I think one of the points that I want to make is that it is helpful if beforehand the community expresses what its needs are to the individual going there. I think if the Director of the program in a particular community can tell the discussant who is coming up how specifically the visitor can help, this would be of some benefit. I don't think I had sufficient information ahead of time about the program, about the needs of the community to plan my program appropriately. Thank you.

MODERATOR DR. KIMBROUGH: Dr. Goldman.

DR. LEON GOLDMAN: I enjoyed the trip up to Yuba City and Marysville just the past few days...I know that in surgery the American College of Surgeons is vitally interested in continuing education, or even recertification of practitioners after they leave medical school, even the recertification of Board members; and this is because the public is clamoring for this and as we see now with Dr. Kaplan here, the Government is interested in this and I think that it is well for the medical organization, organized medicine, to actually lay their own plans in an attempt to carry this out.

How this will be done I don't think anyone knows, but we hope it is not by formal reexamination. We hope that it can be done by some method such as this.

I think the Academy of General Practitioners have already recognized this and they have some method that they utilize for this, so the importance of this is very great and I think that the medical school has a responsibility, too.

When a medical school goes to one of these communities I think the man should know ahead of time who he is going to talk to. Is he going to talk to a mixed group of general practitioners and specialists? I think he has to gear his talk to the audience.

I think it is a great mistake for a faculty member of the medical school to go to one of these sessions and give them a lecture or to give them the same lecture that he may give to medical students and I know that years ago this used to be done. I have had men from outlying communities tell me so. They would feel insulted because that would be regarded in the same way that we teach medical students.

I think when I was asked to go up to Marysville and Yuba City I received a letter saying "We don't want any formal lectures. We don't want any lantern slides." I can see the reason for this. They are afraid someone is going to go up there and give a hard didactic lecture which might be good for the soul but which...doesn't end up with application...

Although I don't think I have the knack...I think a good teacher should be able to teach the practical thing and also work in some of the basic knowledge or recent advances in basic medicine for application.

Depending on the size of the community and the number of doctors present I visualize that this is going to snowball and very soon two or three members will go up together and there will be different sections; and depending on the interests and the specialists present,...they will have general meetings of the entire group. It seems to me that it is easier for two or three doctors to go up, say from the Medical School to talk to 40 or 50 doctors than it is for 40 or 50 doctors to come down to the Medical School because the teaching is the same. The only difference is the locale.

MODERATOR DR. KIMBROUGH: Dr. Kaplan, is there anything you have to say?

DR. KAPLAN: The Federal Government and, I imagine, other governments, only tend to step into areas where a vacuum exists and if the physicians take the responsibility for maintaining and improving their quality of medical care then the Government will only be involved in supplying money or supplying the framework through which this can be done. But if the physicians themselves do not get involved in it and do not take active interest, then I am afraid the Federal Government will get involved and in ways that none of us would enjoy.

(Coffee break.)

MODERATOR DR. KIMBROUGH: Dr. Blacker.

DR. BLACKER: I am the individual caught in the middle of this warfare carried on in Yuba and Marysville. Although I did not see many doctors, I had an enjoyable time. It was beautiful in the spring.

What I want to comment on is whether one, two or three days is the time a visiting professor should spend...

I am a psychiatrist and at Modesto where I was in the month of December it was very important, I felt, that I had an opportunity to spend about three days...I spent most of this time with the resident staff who at that particular time were getting very poor training in psychiatry. I would say that it is only by spending a block of time like three days with the resident staff that I was really able to do teaching in this particular area.

I would also add that perhaps although you have been looking at the question of one, two or three days in terms of the time that the doctor has and the busy physician has to come to these meetings, that perhaps some things happen on the third day that really don't happen on the second day, and some people can get to know each other...

The problem of whether one, two or three days should be considered both in relationship to the needs of the particular area to education, and also perhaps of the need of the particular specialty and the way you can teach that specialty.

DR. SHEPPARD: I am a little disturbed about this talk, like Dr. Blacker, about one two or three days because I am in charge of a program now where there is an instructor or a series of instructors for residents over a period of four to six weeks, and one, two and three days become a little short in comparison to that.

What we found in our program, you are spending the first, second and third day getting acquainted, and perhaps this is what you are observing.

* * *

MODERATOR DR. KIMBROUGH: We will next call on Dr. Carl J. Leonard, Director of Medical Education, Salinas General Hospital

DR. CARL J. LEONARD: Dr. Kimbrough, Dr. Cullen, Dr. Farber, ladies and gentlemen. In answer to the questions, the description of our community is essentially that I represent the General Hospital of Monterey County, which encompasses both the Salinas area and the Monterey area. These are two districts separated by some 20-odd miles, which poses a very important geographical problem.

The Salinas area itself has some 75,000 people and is essentially agricultural, as you may know.

The Monterey Peninsula, the temporarily inundated seat of the Crosby Tournament, is a resort and retirement community with a great deal of tourism.

Our General Hospital, the General Hospital of Monterey County, is a County hospital, as it draws its clientele essentially from both of these areas. We are a moderately sized hospital of 334 beds. Our census is much less than that, since many beds have to be allocated to psychiatric, et cetera.

We have a visiting staff, a good number of full and part-time staff, resident physicians and general practice for replacements.

Of some 130 members of the visiting staff, probably half come from the Monterey Peninsula, and this poses a large problem in geography. It is hard for local men to attend meetings without taking into consideration a 40-mile or more round trip on a busy day.

As to the attitudes of physicians towards continuing education, I really can't speak for the entire medical community, but only for that of my own hospital. I should perhaps explain that the County has four or five general hospitals, three of them in Salinas, two in Monterey and Carmel, and another one south in King City. To my knowledge, the Community Hospital is the only one conducting a full kind of education program, and I can't speak for the others with any great deal of knowledge. I do believe that there is not much in the way of teaching going on elsewhere.

As to our own staff members, the full-time people and the residents, of course, have an interest in increasing their education, and the facilities are there, and the problem of appearing and disappearing is very simple since there are no patients to leave in offices, and such.

Ordinarily our full-time staff of residents attend most meetings fairly conscientiously and they certainly show a distinct interest in furthering their knowledge, and especially so in practical applications.

Since we are a County hospital, the physician attracted to the County hospital is really geared toward patient care and not too much toward research or the solution of research problems. Nevertheless, I think we are all interested in knowing what is going on by way of experiment and research, which can be at least applicable to the care of the acutely sick and injured patients.

The reactions of the physicians that have taken these sessions are, to my mind, quite favorable; but there again it represents the views of our full-time staff and resident staff, since these are the ones that attended chiefly.

Where I have had the opportunity of questioning the visiting staff, they have also expressed keen interest. However, as so often happens, a few think it is a very good thing, but only for the people in their specialty.

I should also state that we have very little experience with this program, since we have had only two Physicians-In-Residence so far during the past year. Judging from the reactions of some other areas, I think it is quite favorable.

For the past four or five years we have had a series of speakers come from the University of California to address us at many of our monthly staff meetings, and these have been especially well attended during the times that such speakers have been present; therefore I feel that this kind of program, the Physicians-In-Residence, has very great potential for a further increase in interest throughout the community.

As to appraisals of accomplishments of the program, I think that we have all come to realize that there are many gaps in our knowledge that we can very profitably plug, and if it does nothing else - which it certainly does - it makes us realize what possiblilites there are in the care of acutely ill and injured patients that we may not be familiar with and that we should be taking advantage of.

As to concrete examples of the present programs, as I said, we are too new in the program to be able to state categorically that this has resulted in this and that benefit. I can certainly state that from the experience of the previous speakers from the rest of California, we have had much concrete benefit.

I can recall for the most part we were not acquainted with such things as the desensitization until Dr. Overstreet came and talked to us about the program, and since then we have utilized this knowledge in many instances.

Now as to the needs of the physicians in the area. We do have fairly good numbers of well-trained general practitioners and the usual specialists in the community. Where our chief lacks and deficiencies are is in the field of the more highly specialized areas, and we need to plug our knowledge gaps there quite extensively . . . that is not necessarily to instruct us, but to realize what possibilities there are in dealing with these questions.

As to the length of stay -- we are quite new in this program, but I would judge from our two previous Physicians-In-Residence that possibly in the non-surgical areas two days would be adequate; but I still think that in the surgical field three days is not a bad stay at all.

We have had the pleasure of having Dr. McGregor in plastic surgery, who stayed with us, and we saved him up a number of nasty problems to deal with, in which he did very nicely and taught us a great deal, both in the Clinic and in the operating room, as well as in the auditorium.

Then we had Dr. Reider visit us as second Physician-In-Residence, and we picked his brain as to questions of intensive-care units, since we are thinking of extending our intensive-care unit to the geographically adjacent coronary-care unit; and we made very good use of his knowledge and talents in this field.

DR. KAPLAN: You said you had a series of speakers come down. What happened to this series of speakers after this program started?

DR. LEONARD: We kept right on.

DR. KAPLAN: Did you pay these speakers when they came?

DR. LEONARD: You can call it that, I guess.

DR. KAPLAN: How did you compare this type of program with the series of speakers?

DR. LEONARD: They both serve the purpose, and I think the Physicians-In-Residence is much more desirable and much superior, especially when it gets going.

DR. WILSON: Let me explain, Dr. Kaplan, this has been done through our Department for years as a courtesy, and we try to get specific speakers whom they want; but it is a dinner meeting, a talk and this is the end of it. There is no clinical application at all; it is a straight lecture.

MODERATOR DR. KIMBROUGH: Are there any more questions?

DR. EDWIN J. WYLIE: I think it might be instructive, in association with this presentation and the others, if we get some kind of notion about which is the most productive way to structure these programs from the point of view of the men in the various medical communities.

Dr. Goldman alluded to the information he has given before arriving; there are formal lectures, informal lectures, large groups, small groups, prepared case presentations and comments. There are a variety of different ways to do it. The question is which has become the most attractive and the most educational, and in what direction should the emphasis be placed.

MODERATOR DR. KIMBROUGH: Dr. Wylie, we will bring this up in our panel group discussion around four o'clock, and I hope we will have answers to those problems.

May we hear from Dr. McGregor?

DR. MCGREGOR: I have very little to say about this. I enjoyed the two days in Salinas very much. I went down prepared with a group of lectures, about six to eight all in total, and with slides, et cetera, to bring to these people the things that were going on in my field, and which I thought they might be interested in. It did not take me long to realize they were not interested in what I was interested in in this field, and then we got over into the clinic side where we saw patients and where we operated on these patients and talked about this particular individual, and it did not take me long to realize that this was the problem that they had and that they were confronted with.

My own personal opinion is that they got more out of the open clinic and the rounds and answering the problems that they were faced with each day then they did with me bringing them things.

MODERATOR DR. KIMBROUGH: Thank you, Dr. McGregor. Dr. Reider.

DR. RAPHAEL B. REIDER: I first want to say something about the value of this program to us, the visiting physicians who are in more intimate contact with the academic community.

Personally, I found this a very enlightening and enriching experience, the three days that I was in Salinas; because whereas I realized that they were faced with a different order of problem than I am faced with in my practice in San Francisco, I never really truly appreciated the true nature of the problem of community medicine in that kind of a setting, until I spent a considerable amount of time speaking and maintaining an active interchange among other interested physicians in the area.

I came to have a new respect for the quality of medical practice in Salinas; and the ability that these physicians had to deal with sometimes very complex medical problems with very limited facilities at their disposal. I just want to point out that in a total appraisal of this program, the value of the feedback from the community, from the local community physician to us in the University can only lead to a better understanding on our part as educators as to what we really owe in our educational processes; and ultimately this should really get back to the nitty-gritty of the curriculum in the Medical School itself.

This brings me to one of these redundant points that we have come across at least on three occasions this morning; that is, the length of stay. The first day that a physician from the University of California spends in one of these communities, I think on that day he is regarded as the visiting emissary from the ivory tower. He is expected to give certain formal presentations, tell what he is doing, give the academic point of view perhaps, and his distance from the practicing physician in the area is quite great.

On the second day we start to know each other by name, and on the third day we are really exchanging case details, truly communicating - if I may use that often-maligned word - on a very intimate and personal level.

In my own case I might say this has even been continued after I left the area. I have been in communication with a number of the physicians in the area with reference to some cases that they presented to me while I was there, and other new cases that I had the pleasure of evaluating for them.

I was discussing this point during our break with Dr. Goldman and he pointed out a kind of reverse phenomenon, that on the first day you are the expert; on the second day they feel that they can perhaps talk to the expert, and with a little less diffidence; and on the last day, on the third day you are there, they realize maybe you are not really so much of an expert at that. But it is precisely at that point where true valuable intercommunication is a realistic possibility, so I would say that the term of residence ought to be somewhat prolonged beyond the one or two day period.

The difference between the two and three days is maybe not very great; but it is still very short and I think the true test of this program has to be what kind of continued evidence of stimulation remains after the visiting man has left.

I want to point out that for myself, at least, I am involved in practice and in a number of community and University activities; and it is very difficult to arrange the logistics to be away for a certain number of working days. But it is no more difficult for me to be away for three days than for two days. It still involves the same number of telephone calls, arrangements for coverage, et cetera.

I want to again say that I enjoyed the experience tremendously.

DR. KAPLAN: You teach medical students and residents?

DR. REIDER: Yes.

DR. KAPLAN: And you would find that some of the things you learned in the community hospitals were passed on to the interns and residents?

DR. REIDER: Without question, it has colored my approach in my teaching activities in the University.

DR. KAPLAN: Do the rest of the visiting people feel that way also?

DR. REIDER: Very strongly.

DR. KAPLAN: I imagine that would be something to expect anyway, but it is good to hear about it.

DR. SALOPEK: I would like to make one comment. One single item came up in our community that may in the future certainly have some influence on morbidity and even mortality. At the end of our meeting, practically the end of it, Dr. Goldman made a most amazing statement to the surgeons and the general practitioners in our area. The statement was completely unexpected and the pattern of what he suggested has heretofore never been practiced in our community by general practitioners or by a surgeon.

Dr. Goldman made this statement, that when he was operating, if he went into an abdomen and there were many adhesions that had nothing to do with the medical situation, that he would have nothing to do about releasing or attempting to correct these adhesions.

Well, in my practice in Marysville and Yuba City, in my own practice and in my work with the surgeons we have there - and we have about four well-trained surgeons - I don't think that I can ever remember anyone or any one of the general practitioners that don't make every effort to free and release every adhesion that they see, in the upper abdomen or feel something stuck in the pelvis from a previous operation; they will attempt to release that, even if it has nothing to do with the surgery in the upper belly.

The mere fact that Dr. Goldman informed them that by releasing adhesion you are only going to form more adhesions and you are going to probably cause maybe greater trouble than existed before with the present adhesions; really, that startled our men up there and I think it gave them all a tremendous food for thought in the manner in which they operate in the future. I think this was a well taken point and was highly educational, and I think it will change the practice of many of the surgeons that listened to Dr. Goldman's speech.

MODERATOR DR. KIMBROUGH: Thank you. We will next hear from Dr. Melmon about San Luis Obispo.

DR. KENNETH L. MELMON: Dr. Anderegg from San Luis Obispo is attending a previously scheduled meeting at the University of Southern California, so the people in San Luis Obispo sent a letter instead. The letter summarizes the situation as they see it and gives another opening to something that I don't think has been considered here this morning.

It is addressed to Dr. Farber and from Dr. Anderegg, who is Director of Medical Services in San Luis Obispo. He apologizes for not being able to come because of a previously-scheduled Regional Medical Planning Meeting involving faculty members from the University of Southern California.

Already you can see here that conflicts can be brought up in the communities by a number of universities participating in live or diverse programs, which may not be carefully coordinated, so they can get the maximum from both sides.

He says, "I hope this written report will reflect in some small way the reaction of our medical community to the recent visit of Dr. Kenneth L. Melmon."

"San Luis Obispo is a city of approximately 25,000, the county seat of San Luis Obispo. The main source of income in this area is agriculture and tourism, the latter being confined chiefly to the summer months.

"San Luis Obispo General Hospital is a 206 bed hospital of which 140 beds are utilized in the treatment of acute, medical, surgical and psychiatric cases. The hospital provides the only psychiatric facilities available within the county. This consists of a Community Health Program providing an outpatient department, twenty-six inpatient beds and composed of a staff of two psychiatrists, a general practitioner, three nurses and eight psychiatric social workers. The remainder of the beds are divided between medicine, surgery and a small pediatric and obstetrical department. The medical and surgical wards contain approximately forty beds apiece. The non-psychiatric portion of the hospital is staffed by two general practitioners. In addition to the full-time county employees, we have a medical staff of fifty-four active members who are in private practice in the area.

"The attending staff at the San Luis Obispo General Hospital is composed primarily of specialists, all major specialties being represented by from three to five practitioners. Approximately twelve men on the staff are engaged in general practice.

"Because of the high proportion of specialists within this rather small group, we entered in to the Physician-In-Residence Program with some misgivings, not to say skepticism. We felt it would be most difficult to find an area of common interests for such diverse specialists as ophthalmologists, psychiatrists, dermatologists and oral surgeons; however, through either a great stroke of good fortune or keen foresight on the people assigining physicians, Dr. Kenneth L. Melmon, Chief, Division of Clinical Pharmacology, University of California, San Francisco, was assigned as our physician in residence.

"Due to my lack of experience in arranging this program, Dr. Melmon's presentations were confined to four lectures presented at the hospital as breakfast and luncheon meetings, January 6 and 7, 1968. Seventeen physicians attended the initial breakfast lecture. Twenty were present that noon. Fifteen attended the breakfast lecture the following morning and forty-two attended the luncheon meeting. Although the subject matter of the final lecture may have had more general interest than those previously presented, I feel word of mouth reports of Dr. Melmon's meetings led to the large attendance at the final meeting.

"In an effort to assess the effect of this series of the staff, I sent out a questionnaire concerning attendance, value of the meetings, interest in further meetings, and suggestions for change in format. I was gratified by receiving approximately a 90% response to my questionnaire. In all but two instances comments on the program were most favorable. The physicians stated they would be most anxious to continue the series and several suggestions concerning subjects for further sessions were made. I might add the physicians finding fault with the program have been known to question motherhood, pure milk, and the American way of life.

"In summary, I feel that the Physicians-In-Residence Program in San Luis Obispo General Hospital was a success. I feel that future meetings would be even more successful inasmuch as we will be prepared to work out a format that effectively utilizes the skills of the visiting physicians." I think Dr. Anderegg has pointed out many of the problems that are faced by the Medical Director or Medical Education Director before he has been exposed to the potentials of this program. He tries to say, I think, that it is not easy for him to decide what the community wants, let alone express this to the person who is going to be sent down into the community to help them.

I think, therefore, that the onus in terms of the early phases of this program is largely on the basis of its directors from the academic standpoint; and that it is extremely important that they pick individuals who have some dexterity in being able to accommodate to the needs that they may not be able to anticipate, or at least cover very broad areas which might be of basic interest to anybody related to medicine in general.

I went down prepared to give some lectures also, but it turned out that there was no reason to give them, because they would have excluded such large portions of the group. It started out with a general discussion of hypertension, but it became very clear that this is not what they wanted (a discussion about a specific disease); and in asking them what they did want for the next three sessions, it ended up they wanted some discussion on how to use pills that would change edema, how to recognize this and the gram negative sepsis, and what drug toxicity really was. None of these three were anticipated and I was not prepared for any of them, with the exception of the afternoon time which they gave me or the evening before the morning breakfast to prepare.

I think I could have done a better job if I had some time; but I think it was important for them to realize that on the spot, individuals could not lend expertise, but at least an organization to their approach which was representative to the academic community.

If an individual would not be adaptable to the community's needs, perhaps the 40 people that attended at the end may not have been there.

Then I think there has to be a great deal of dexterity to the future of this program. My own feelings are that the outlines which were sent to us were reasonable; that the communication between the hospitals and the physicians before they arrive on the spot was very lax; and because of this neither one knew what was about to happen.

I think there was a great deal of trepidation on both sides - there has to be - and I know when I spoke to Dr. Williams before I went down, I asked him what kind of a time he had, and I thought, "My God, I can't do those kinds of things, talking about rheumatoid arthritis or whether cranberry juice makes the pH of the urine more acidic," and I had no idea whether the people in Southern California would be interested in cranberry juice. It seemed like they were more interested in grapes; but it was very difficult to go down without adequately preparing, and the major part of the preparation may come from pre-meeting with the Medical Director and the potential faculty members before he arrives on the scene. I think that would be very helpful to me. I don't know whether it would be to other participants. I am just bringing this up.

There are other ways in which I think we can improve what might be going on between the community and academicians. One of the major things that I saw happening was that the gap (which was expressed by the last speaker, which can be created between the University and the practicing community) is largely there because of this mystery of what goes on between the two sides. Maybe we are both somewhat defensive about our activities, and maybe we are both somewhat mysterious about what we are doing; but during the discussions that were had between the two groups (usually after the lecture or on ward rounds or going through the pharmacy or intensive-care unit) . . . they began to realize our common meeting ground and common problems.

They do have a lot to teach, not so much on the basis of what we would teach a resident or faculty member or our house staff or student; but more about what we would teach each other on a faculty level.

There are other things which we can contribute to. For instance, when I was in the library for anybody to come to us that wanted to, I was very surprised that the pharmacist came up and wanted to discuss how they should manage the problems of inadequate prescription writing or dangerous prescription writing with the physicians. They had no communication. They wanted to know how to become more familiar with the information which may be basic to adding drugs to I.V. bottles, et cetera, which they were fearful would be basically or chemically incompatible as far as the physician's prescription.

They wanted to know whether or not there were sources for drug information centers. They wanted to know what the University would be doing in relation to its responsiblility in contributing information related to drug reaction. They wanted to know how I assessed the function of their library. They wanted to know which books I should order for the group after I had a chance to be exposed to all of them, and they wanted to know how to make their library resources more available.

They asked me whether or not an average of two hours a week in a group which volunteered this was enough for reading for an average individual in this area and, if so, what they would read. They wanted to know a little bit more about the ways in which an evaluation of literature could be made, so that they could actually scan it more effectively and eliminate useless information.

These were many areas which came up in the course of those two days, and they also wanted me to know that they were interested in things that we had offered, as long as we could offer on a common level. They were neither interested in my coming down to them or them coming up to me, or vice versa; and as soon as that attitude began to rear its head, they excluded members of their own community, which was rather interesting. The first morning when two people decided they would attack the ivory tower, and before they had a chance to ask the third question, they were asked to leave by the rest of the group.

I was impressed by this meeting primarily because I thought that there are any number of benefits besides the direct communication on specific case levels or specific topics which could be brought out in a discussion with the community group.

I was most impressed by the needs they have for unrelated day-to-day management of patients. I was surprised that nursing aides, for instance, were primarily responsible for passing out drugs. I was surprised that these nursing aides had no particular understanding or way of assuring themselves that the patient had actually taken the drug; and I was surprised that nurses were unable to measure blood pressures and never bothered with counting respirations and put a common number down on all charts. When it was discussed in some detail as to what they might do, they were very attentive and interested in changing.

You really have to dig into the community's practice, and I hope in the future, as this becomes less of a general course, that they (i.e. community physicians) can find their real needs and express them to the Directors of this Program, so the Directors can be responsible for sending down a specialist, if he is needed; or keeping a specialist away if he is liable to hurt the program or hurt the interest in post-graduate education.

MODERATOR DR. KIMBROUGH: Thank you very much...I understand Dr. Huitt from Chico has arrived and we will call on him. Dr. Huitt, the Chairman of the Program Committee of the Enloe Memorial Hospital in Chico.

DR. CARLTON HUITT: ....For those who may not be acquainted with Chico, it is a town approximately 180 miles north of here in the Sacramento Valley, at the east edge of the Sacramento Valley. It is a composite community of agriculture, Chico State College, and it is a distributing point for multiple enterprises. Some of the drug companies have their representatives in Chico, some of the trucking warehouses have their loading facilities there to distribute to the more rural towns.

This gives us a county population of approximately 100,000. We have the Butte-Glenn Medical Society, which comprises two counties and has approximately 120 physicians. Of this group approximately 30 represent the specialties, and they are located chiefly in Chico. I think there are four specialists in the other small towns, the towns in the area around us.

Particularly in relation to Butte County are Chico, Paradise, Oroville and Gridley. And over the the Glenn County area there is Orland, Willows, Hamilton City, and some smaller areas, such as Butte City and Princeton.

Of this area the total west side is covered with general practitioners, and they are certainly in an agricultural area, and their practices are so dictated by the people there and the lack of doctors. The general practitioners in our area see approximately 30 to 40 patients in a day, and if you miss a day or half a day of work, you see twice as many the next day. This is a fact of life that we learned to live with.

In our hospitals in Butte County, we have a total of seven. One is a County hospital, the others are community hospitals. Some are crowded and some are presently in the non-profit system.

We like to think of ourselves as being sort of a hub of the medical practice in Butte County. This may be somewhat idealistic, but at least with our drawing trade area around our immediate community this seems to be true. We received a fair number of referrals in Plumas County, the Quincy area, some from the Susanville area, where we receive referrals in our area, particularly specialist groups from Willows and from Red Bluff.

The attitude of the physicians toward continuing education in the past involving circuit lectures and the radio programs -- we were usually fortunate to have the same four or five fellows showing up for each program. These four or five stayed well informed of what was going on and the other 120 received what postgraduate education they did receive from their own individual specialty meetings.

With the advent of the Physicians-In-Residence program, we have had two, Dr. Griffeath and Dr. Karam. Both have been well received, both were timely, and they were received by a fairly large number of physicians.

We divided our three-day programs maybe somewhat differently than some of the others. As our community of medicine is spread out, we devoted Tuesday morning to the visiting professor going to Oroville, to the County Hospital, where they have two or three paid staff and multiple open staff attending; and they covered topics somewhat pre-assigned, and also a grand rounds function. They seemed to be quite well received. Approximately 15 to 20 physicians attended the Tuesday morning conference, grand rounds program.

Tuesday afternoon was left free for the physician who was visiting to get acquainted in the community, to visit the hospitals, or do what he felt was worth while.

We devoted Wednesday morning to the paramedical groups. hoping that the nurses from our general area would take advantage, which they did on both occasions. The first speaker spoke to approximately 60 nurses, and the one this last week spoke to approximately 75 nurses and nursing students. Some of these came from the Yuba City-Marysville area, some of them came from the Red Bluff and Redding area; and I believe we had some from Quincy and Susanville -- so we drew from a large geographic distribution. The talks were in a practical vein and could be used in the rural communities, which was very beneficial.

The Wednesday afternoon session was primarily directed toward the physicians. I had something to do with this decision on time, because a large segment of our physicians take off Wednesday afternoon to attempt to either catch up on their paper work or their golf, or something else, and I thought it would be a good time for those who were interested to catch up on postgraduate eduation. We made it available at that time and we were well received.

On Wednesday afternoon we averaged about 25 physicians for the two programs thus far.

Since we are trying to work out a three-day program, we did have a Thursday morning session. Each of these had approximately 20 physicians attending. On the first speaker we attempted a Thursday afternoon session at Sutter Hospital in Willows. This worked out quite well for the physicians in Willows because the three who attended the Wednesday conference at Chico stayed busy on Thursday morning and Thursday afternoon, and the other two physicians took off Thursday afternoon, and were able to greet Dr. Griffeath and review their hospital program and planning for coronary care. This is what they were interested in, and the two physicians made themselves available to work with someone who had more experience and I think they mutually benefited at that time.

It did not seem practical on this particular visit to have someone go to Willows because of the total five doctors, and also because of their busy schedule. It is somewhat hard in a general community of this sort to take off and receive postgraduate education from the time that you normally are in your office....But I think the fact that the two visits we have had we have run somewhere near 70 to 75 nurses for specific training and 60 physicians have had some specific training at each time, which I think has proven very worth while.

The gentlemen were well received. Our general topics that we think would be worthwhile should be an interplay of general practical medical terminology that can be used by the physicians and nurses in the area, plus at least a running glimpse of what is going on academically and what we can expect in the future that will sift down for practical use.

I don't feel that there is a great point spending hours discussing in the latest research on that project which does not have any foreseeable future for us in the practical general community.

There has been this discussion about the expert or the visiting fellow who comes out with slides. I feel that slides have a definite benefit. One asset to the fellow who is going to show slides to supplement his talk would be to have copies of these slides made available to pass out to the participants in the program; so when you see some information that you can specifically use, you have something to refer to, and maybe jot down extra notes.

The fellow who is using slides and does a good job, he elaborates on what is on the slide; and if I had the same material in a handout and I could add some of his ad libing, I think this would make the slides worth a lot more. To come and spend an hour or two and show a hundred slides and say, "Isn't that nice?" would be of no benefit to us; but the slides supplemented by some handout material that covers the slide material...would be very beneficial, particularly in factual medicine and particularly in some new concepts that have been proven satisfactory in the academic center...

At the most recent session we had this discussion of the use of the oral medication for diabetes, and there were at least four or five physicians there that did not realize there were two different actual types of the oral diabetic preparation medicine. They commented after the session that they planned to change their approach to treating the patient with diabetes somewhat, just from the discussion of what went on in the session. I think this is worth-while.

Also our first speaker came at a very timely time, when we had just completed one coronary care unit, and after a six-months history of function we had gone through our growing pains in our coronary care unit. We were at the time of the development where we could stand a repeat by an expert to come and give us more guidance.

We have put in a new pulmonary therapy unit, and soon we will be in the position to benefit from someone who could come to see what we are doing and be able to offer us advice and give us some guidance as to how to better utilize the facilities that we had.

It is not too difficult sometimes in a small community to acquire money to buy equipment, but it is exceptionally difficult for the physician to acquire knowledge in how to use what is there...if they have not had a little personal guidance or personal experience. Thank you.

MODERATOR DR. KIMBROUGH: Are there any questions?

DR. JOHN H. KARAM: I just returned yesterday from Chico, so this has some advantages and some disadvantages. I am still a little bit warm maybe from the trip, and I have not had time really to think out all of my impressions as yet.

The other advantage is that it is fresh in my mind and I have had a few experiences that I would like to relate. I would probably state that coming a little late in the program I could see many things that jelled for me which other people (P-I-R) that visited the area may not have had.

Sometimes a lecture program is not going to really reach the doctors quite as well as maybe a smaller group with maybe more rounds or personal attention to individual patients.

I think if I had to go back again now with the experience I had knowing some of the needs of the community and knowing Dr. Huitt, who was a very gracious host and moderator of the session - he organized it very well - he could offer suggestions to me that might alter my approach. I think communication with a smaller group would be important.

I think the one thing I did note, maybe 20 years ago as Dr. Roberts brought out possibly it was the economic things that have really changed in the communities outside of university centers, so that once when a doctor said, "What good would it do to know how it is done in the medical center because the patients cannot always afford all of the diagnostic and therapeutic approaches?" Those things are changing because of Medicare and I found through my experience in the community that many of the patients have the care available to really benefit from the ability we possibly have at the University with some of the newer approaches in therapy, which were not previously available...also it is possible to get most of the tests that we once did not have accessible done in a short time.

I think the benefits of continuing this program are especially useful in my field, and the one-day, three-day discussion is not clear. I can do as much in one day now as I did in three if I went back there, because it took a lot of time to learn the problems of the community, but it might be good to go back five days again after the first introductory visit; knowing more what my field is, there would be selected patients and I could contribute more.

Facing a large audience, general practitioners and nurses, it is difficult to select the information that can be used by all of them, and this is one of the things where a smaller group might be better.

MODERATOR DR. KIMBROUGH: Are there any questions? I understand lunch is being served.

(Luncheon break.)

* * *

MODERATOR DR. KIMBROUGH: I think we are ready to continue with our Physicians-In-Residence Conference. Next we will call on Dr. John D. MacCarthy, Chairman of the Program Committee at Merced General Hospital.

DR. JOHN D. MacCARTHY: There is a sign on one of the best medical educator's walls that I know that says, "The main art of medical education is to keep the medical student awake," and I would like to start out after such a terrific dinner as we had by saying that I am purposely going to make my discussion a little bit more controversial, to maybe overcome the natural post-ingestive somnulence that some of us are suffering from.

To start out the controversy, I would say that Merced is the most attractive city in the California Central Valley. I certainly would not want anybody in from Virginia to go back and not know that. Merced has about 30,000 people, the tenth ranking agricultural county in California. It has a moderate amount of light industry and a very aggressive growth in agribusiness; and if it has not been washed into the Merced River by our most recent rains, it is a beautiful community to live in and go back to.

I think this brings out, though, a problem that has not been discussed today in this group, and that is the social problems. Ours are not as bad as many valley communities, but there is a tremendous social problem in Central California in the sense that a small group, a small proportion of the community, owns the major part of the assets. In some communities it may even approach ten percent of the people owning 75 percent of the total assets. This means that you have a tremendous number of people who are in the disadvantaged economic groups and does lead to a slightly different problem in medical care than you might find in the Midwest, from which I come.

Indeed, as a newcomer to California, I am impressed that our economy has not perhaps - at least in the agricultural areas - progressed as much as we would like to think from the ancient, hugh landholdings of the Spanish ranchos. At any rate, there are 120,000 people in Merced County and there are at least 50,000 people in the contiguous areas of Madera-Mariposa and Stanislaus County who look upon Merced as the shopping center and as a major medical center for their needs. That is true even though Merced has only 30,000 people in it.

We have two hospitals in Merced and neither of them has an intern or resident staff, and I think this is an important difference from what some of the other people have presented. All the people we are talking about getting educated coming into these conferences are busy doctors who have left their practices and have come to hear what you, the professors have to say. I agree with one man who pointed out; we have a man in general practice in our community who is supposed to see 100 patients, and he leaves that practice to spend one day at the visiting professor's rounds. He will then have 200 patients the next day -- and these are not exaggerated figures.

This is one facet of the problem which we have in our community, and I suspect it is rather general among many of the other communities like Merced that we are going to talk about today.

At any rate, we have two hospitals. One is a general hospital; this is a community-owned hospital. It has about 100 active beds and another 150 specialized beds in which chronic care facilities or psychiatric are especially well represented.

We have another hospital . . . it is Mercy Hospital, run by the Dominican Sisters, and it has about [illegible]00 beds.

We have done things just a little bit differently than perhaps has been implied in our situation, because of all our doctors go to both hospitals. It is not closed. There is a fairly good working relationship, and so we have literally half of our conferences at Mercy Hospital when the visiting professor attended, and the other half at Merced General.

We are using both facilities and we think this works out exceptionally well, at least in the Merced community.

Another thing, we have to stress is that during the past ten years Merced has made a transition in medical care in the sense that up until ten years ago general practitioners easily outnumbered specialists; but within the last ten years, and possibly only within the last five, the preponderence has shifted very strikingly from men in general practice to those in specialty practices.

We have a major problem . . . it was possible for two of us who did it in jest, to predict precisely who was going to come to the medical meetings which were held by the University of California program of Physicians-In-Residence. We both made out a list in jest, and this was very, very close to the actual attendance at our seminars.

This, I think, points out a sharp dichotomy in many medical communities. On the other hand, I am not trying to say older practitioners are less academic than younger ones; but if we could just take them as a group (there are individual differences within the group, of course) the older men in our community in general apparently have no genuine interest in continuing medical education, as we had predicted. Almost none of the men who we predicted would be absent showed up at any of our meetings; and, on the other hand, those we had predicted would come on the basis of their interest and past experience were mostly younger men, and most of them had had some kind of at least partial training in a specialty.

Whether these older men are uninterested because they only think they are going to be practicing another ten years and don't want to get involved; whether they are the men who are unwilling to take time out from their offices and lose a little bit of money coming; or, as I think, whether there are some hidden psychological defects which made them unwilling to come, which is possibly the exposure for the first time in 15 years to new ideas -- it could be catastrophic to them psychologically. By the way, I am an internist; I am not a psychiatrist.

What kind of problems these gentlemen have, I think is significant, and I think it is psychological rather than actually physical.

On the other hand, among this group of men we encountered simple apathy. There was no hostility, no resentment, nothing but apathy.

Among the younger men we actually at first encountered just a shade of antagonism. This came out very clearly. You get a feeling from a doctor who just came from Stanford, for instance, and is now starting to practice in internal medicine with a sub-specialty interest in pulmonary disease. His reaction is "Why the dickens should we get a guy down here to talk to us about lungs when he may not even be as well qualified as I am?" And that is true.

I think we have been able to overcome that in our community by pointing out that we hope the older doctor would be more willing to listen to a University professor than they will to someone who is openly competing with them for patients. How successful this is I don't know; but it certainly is true that in any community like Merced, where you have a large number of young specialists who just entered the community, many of them are extremely well qualified but they won't be listened to.

At any rate, we think we are able to overcome this particular kind of antagonism with a demonstration that these fellows will now get more referrals from the older doctors who understand a little bit better how much more they know about the particular field than the older man does.

I think that the hostility which was originally expressed by a few of our younger specialists has completely dissolved on this basis.

There are a couple of other things that I would like to say, and that is, most of the younger specialists that I know in Merced (and this is true of a few of the younger general practitioners) feel very strongly that the ideal post-graduate medical education is a period of time and study at a University Medical Center. In other words, the professor in residence is a second, less desirable approach to medical education, possible far more practical at the present time than the kind I just mentioned.

I would like to say that we would hope that everything is done, and we hope this is a continued program, to develop the opportunities which might eventually be there for more formal residencey of the doctor in a major medical center, as is being advocated by people like Diamond.

Merced, I would like to stress, has made use of other medical resources for education besides those offered by the University of California under this program. We were very fortunate in having Pacific Medical Center come down about a year ago and give an excellent program in cardiovascular techniques and understanding. This was a shade better attended than our University of California seminars have been, but that is because it was so much more generally applicable than the lectures that have been given. It was planned that way and we thought it was superb.

In this particular case it was a team approach. There were three people that came down from Pacific Medical Center, and someone else has alluded to the teaching approach on these teaching programs. I would certainly agree there are some circumstances in which this is much better than a single professor. We particularly benefited in the nursing staff from that in the University of the Pacific.

As far as our structure is concerned, what we have asked the professor to do, we think that the three meetings a day are ideal. It is a breakfast, lunch, and just-before-supper meeting. That is the way we set it up.

Some of these are held at Mercy Hospital and some at Merced General. Then in between these more formal lectures, there is time for the doctor who is there to be taken on rounds by individual physicians or for little informal group seminars, or even for actual teaching of techniques, like a renal biopsy.

In regard to our attendance, we have a total staff at Merced General Hospital of 68, and again to emphasize they are essentially the same staff as at Mercy Hospital. As I indicated, those of us who really made an effort to estimate were within one or two of exactly who that attendance would be. Twenty-four different doctors came in and spent part of the time learning something, and seven doctors came to every one of the lectures that were given. We averaged three paramedical personnel during that period of time.

You may not think that this is very good, and I know some people that told you about 75 percent of their staff coming, and things like this. We are not at all discouraged by this, because again you have to go back to the basic tenet that there are still babies being born in Merced while this is going on. There is no intern or resident to do it. Our doctors have to go out and do it. There are still people being brought in from automobile accidents, so we feel this is a pretty good attendance.

In regard to the actual advantages to all parties concerned in this kind of a program, one thing we felt that has not been stressed so far is the fact that it does give the two hospitals a chance to work together on a common goal toward improving medical education; and as a result of this, for example, the nursing programs have gotten together and they are giving joint nursing programs, which were unavailable before. We feel that this has tremendous opportunities.

Another benefit that comes from it is that some of the doctors are stimulated to use new lab work and new tests that they had not really thought about using or understood using before. As a result of the University of California visit which we had, we are using a washout technique on our IVP's, which has not been heard of before in Merced, and I daresay would not have been heard of for another five years, had Dr. Coleman not come down and mentioned this to us.

We also had our first renal biopsies performed, which is another thing that was not ever done in the community before.

As a result of the program given by Pacific Medical Center, we have had a marked increase in the number of cases that had blood gas studies done in the laboratory, another result of stimulation.

This is another aspect to practice in a community like Merced which perhaps is a little different from a university medical center or a major community, and that is individual competition between individual physicians. For example, Dr. X won't ever refer a case to Dr. Y because they run in different packs, so to speak. We feel that this continuing education program of any kind helps to overcome this kind of narrow pettiness to which we are all a little bit too inclined.

In regard to the length of time, I think three days is too long. It is too long from our point of view, if not from anybody else's. We felt that two days would have been better. I think that as this program goes forward, as we get more professors, some of that first day business that you mentioned to us will break down so you will be starting on the second day psychologically at least. That is the way we hope it will work out. But I think it will be fair to say that the average doctor who is going to go to these things at all is going to feel saturated about the end of the second day.

MODERATOR DR. KIMBROUGH: Thank you.... we will hear from Dr. Ward Evans, Chief of Staff, Exeter Memorial Hospital.

DR. WARD EVANS: There are three of us here from Exeter...a rather small town; and the reason there are three of us here is because we are not here only representing Exeter Hospital, but also the Tulare County Medical Society...

Exeter....is in Tulare County, which is in the San Joaquin Valley. It is a small town of 5,000, an agricultural community in the citrus belt of Central California.

There are all types of people there. There is a good deal of wealth, there are also poor people, and a lot of people in between.

Our medical community in Exeter itself, we have 13 doctors. About half of these are specialists and also the people of the community are quite interested in the hospital and in medical practice in Exeter. The hospital, which is about seventy beds, is a non-profit corporation and is sponsored and built and promoted by a group of laymen, who are particularly interested in this.

Another fact about Exeter which is important for an understanding of the situation is the fact that it is really a neighborhood in a larger community. The larger community is Tulare County, which has a population of about 200,000. There are six private hospitals in Tulare County. There is Exeter Memorial Hospital, Lindsay District Hospital and Porterville District Hospital. There is a hospital in Dinuba, a district hospital in Visalia, which is our largest town, and a district hospital in Tulare. In addition, there are two county hospitals and the Porterville State Hospital with about 140 doctors in the County Medical Society.

With that as background, when this idea was first brought up in Exeter to bring a visiting professor from the University, actually bring him to Exeter where he would see patients and be in contact with the other doctors, there was heard some skepticism from some doctors. First of all, there was skepticism that the "professor" would actually come to Exeter, which was inconceivable; and if he did come, he would probably turn around and take the first flight back to San Francisco.

They were not convinced about the program, but by the end there was a good deal of enthusiasm which was only latent at the beginning; and a number of comments from people that this was definitely a good program. We think we can improve it, and let's keep it up for the next year.

Our first visitor was Dr. Harold Lyons. He was very tactful and handled the situation very well. As concrete results of his visits, I can't point to any figures or percentages, but we did have a problem there where some of us thought that hysterectomies perhaps were being performed a little too often and unnecessarily; and since his visit and without hurting anyone's feelings, this trend seems to be reversed, and we think that is a tangible result.

Later Dr. Wilson was there on pulmonary problems, and we had many interesting discussions and a program toward pulmonary function laboratories is now under way in Exeter, and Dr. Sargent can tell you more about that.

One of the most important things, in my opinion and in the opinion of others in

Exeter, is the personal contact. Now, you might read in the Surgery Magazine where Dr. Blaisdell says that you get some trouble following vascular stasis because of macroembolization. That is a good idea and you can forget about it. But if you are talking to him, and he tells you this patient of yours died or got in trouble because of macroembolization, you tend to believe it and the next time you keep it in mind and do something about it. All these are tangible results which may be hard to put down in figures, plus or minus, but are, nonetheless, tangible.

The other communities in Tulare County, getting wind of what went on in Exeter and Tulare County Hospital, have been a little bit envious and they want in on the program too; and the County Medical Society has considered this in some detail. We have had several meetings about it and the result is that we would like and would propose to have someone down at least once a month. This is what Tulare County would like to have.

In paying for it, we believe we can pay at least for part of it locally, and the mechanics of working it out are a little bit vague yet, but we think that we have that under control too.

We feel that as the program went in Exeter, that we were at fault locally in not having more patients available for the visiting men; we feel that this can be corrected both by having patients in the hospital and perhaps running an out-patient type of clinic at the time he is there.

To do this, I think we would need a little more advance notice than we have had this year about who was going to be there, so that we could bring it up.

Dr. Sargent, who is our local purveyor of continuing medical education and pathologist, has some more information and a few remarks. Dr. Sargent.

DR. JAMES SARGENT: To amplify Dr. Evans' remarks and after hearing what the discussions have been this morning, our problems are perhaps somewhat unique and somewhat related in that we do have a large number of hospitals for relatively small communities.

Then we have this logistics problem of supply and demand, getting everyone in one location that is convenient both for the consultants and the doctors. It is not a matter of whether this program should or would continue, it is only a matter of the mechanics of working it out.

This grass fire took hold at a relatively small community hospital such as Exeter, which in most people's minds does not deserve existence, and it spread to the neighboring communities and was rapidly picked up by the Tulare County Medical Society.

Part of their Program Committee this last Thursday night at the Medical Society meeting was the circulation of a questionnaire... The questions were as follows: "Are you interested in postgraduate programs:

"a. In Tulare County?" The answer was 94% yes.
"b. In your hospital?" The answer was 84% yes.
"c. At a hospital within ten miles of your office?" The answer was 71% yes.

"Would you be interested in formal lectures?" The answer was 82% yes.

"Formal planned rounds?" The answer was 78% yes.

"Informal teaching rounds to include your patients?" The answer was 78% yes.

"How often do you think such sessions should be held in Tulare County?" Monthly, the answer was 50% yes; every two months, the answer was 40% yes. That corresponded to 90% of the physicians.

"How often do you think such sessions should be held at your hospital?" "Monthly?" The answer was 42% yes.

"Every two months?" The answer was 50% yes, so the toal was 92% who were for a monthly or bi-monthly sessions.

"For the community hospital, would you be interested in planning such conferences?" 80% said yes.

"Would you be interested in actively participating by presenting cases?" 80% said yes.

"Would you be interested in passively participating by attending but not presenting cases?" 99% said yes.

Some of the suggestions that we got, as far as concerning the program, ranged from the sublime to the ridiculous.

One ridiculous suggestion, which is really in a sense of the word not that at all (simply that the mechanics could not permit it) said that we could use three men, for three days at one time and in three hospitals.

They expect every form of medical education on the spot; and again the local doctors, the County Medical Society, said this program should not be funded but they would be willing to individually fund the program to get it going at the level we would like to have it.

What does all this accomplish? Well, the present outgrowth of this plan has been:

1. Drawing communities together, heretofore feudally isolated, where there are men in our communities practicing for 15 or 20 years, who are seven miles apart and who have never had any part of each other.

2. Structural changes in community hospitals to construct staff rooms, libraries, et. cetera, for the specific purpose of accommodating consultant program and continuing medical education.

3. An increase in the percentage of autopsies will ultimately reduce the morbidity and mortality incidence. Men attending post-mortem examinations; we know the result of this is going to reduce this morbidity and mortality incidence, which is too high at the present time.

4. Consultants' discussions have been excellent: i.e. Dr. Wilson and Dr. Blaisdell; and we have handled the problem of documenting their lectures by having transcribed dictation which the secretary took off, and we have had Xerox copies distributed to the entire County Medical Society, and the requests have absolutely been overwhelming to our Xeroxing. It has been very highly gratifying. These are not program lectures that you, for example, drop in File 13.

5. One can tell by talking to the individual...person-to-person contact with the program, having the lecture, and then have the material to go over more at their leisure, that there has been a great deal of benefit from this type of approach. This, of course, produces a second benefit of great interest in in-service staff training programs, both for physicians and for paramedical personnel, who are literally clamoring at the door every day for new types of programs.

6. It has been suggested by all those concerned with the program that, if possible, whoever is to be the consultant for a given period of time should be tied in with the County Medical Society meeting as a kind of a climax to the visit.

7. There are other benefits that accrued from this, as , for example, the establishment of pulmonary function laboratories, which is more on the drawing board than reality now. The establishment of blood gas equipment in many of the laboratories, which had not previously existed...all added together, we feel it has been an immensely successful program.

DR. KAPLAN: Did you say the physicians are willing to pay for it, if somebody else was not?

DR. SARGENT: Yes.

DR. KAPLAN: Do you have a percentage?

DR. SARGENT: No. This was drawn up rather rapidly before I left Thursday night at the County Medical Society meeting; but the hospital administrators with whom we have talked, and the physicians with whom we have talked, have indicated that they would be willing to fund this program if no other funds were available.

DR. KAPLAN: The other things...you say there was an increased rate of autopsies. Do you know the increase in rate?

DR. SARGENT: Yes, very definitely.

DR. KAPLNA: Do you know from what to what?

DR. SARGENT: No, I don't have that figure either, but it has increased that is very easy to document, of course.

MODERATOR DR. KIMBROUGH: Are there any other questions?

One of the first to go down to Exeter in the Physicians-in-Residence Program was Dr. Harold Lyons. Could we have some comments?

DR. HAROLD LYONS: There is not very much to comment about Exeter. It is a small town and one of the most delightful towns that I have ever seen. It is a town you hardly want to talk loudly in. It is very quiet, beautiful, a very pretty town, and I can understand why almost half of the doctors were from the College of the Medical Evangelists, because it was about as close to "Paradise" as you can get. It is really a lovely town.

Like all small towns, there were certain problems and certain logistics problems as far as patient load is concerned; in the fact that eventually hospitals will tend to specialize, whether they like it or not, much the same as doctors will.

It is ridiculous to have six hospitals each delivering 25 or 30 or 40 obstetrical babies a month. You can't do an adequate job. It is not fair to patients, and it is certainly an uneconomical approach to the whole problem. They can be siphoned to one central hospital where they get adequate care and training and actually have adequate facilities.

It is always difficult to run an obstetrical service without a house staff of some sort, and of all the things, practically the only thing that was unfortunate in this hospital was the particular obstetrical setup that they have. It was not adequate and it was not adequate for the demand and adequately followed.

I don't say this to hurt anyone's feelings, because people don't learn by what they know and do right; they learn by things they do wrong, and I am sure they will or have taken care of them already.

You always have a feeling, when you go to one of these people, that reminds me of the story about the little boy who was in the second grade and very bright and gave the teacher a lot of trouble. She did not know what to do with him. Finally she called him up one day and said, "Write me an essay on Socrates." So he went home and the next day he came back with a sheet of paper and walked up to the table and laid it on the table upside down, and she said, "What is that?" And he said, "That is the essay on Socrates." She turned it over and there were only three sentences on it. One of them said, "Socrates was a very great man." The second one said, "He told people what to do." And the third one said, "They poisoned him."

You have opposition when you go into communities and you don't know anyone, and you don't know exactly where the feelings go. I think it is terribly important that you approach these communities, as has been expressed before. There is a certain antagonism--whether you are aware of it or not--and you have to be exceedingly careful. You are asked to go over a series of cases and in this particular hospital there were apparently too many hysterectomies. Now, everybody can come in from the outside and say, "There are too many hysterectomies." All you can say is, "You are not justifying the ones you are doing." They will change, but when you walk in and you are saying, "You are doing too many," then you antagonize somebody from the beginning. The soft approach is terribly important in getting into the communities from the beginning.

The didactic lecture type of thing, I don't know if this is what the areas want or not. I think that is something that should come out and has come out to a certain extent so far.

MODERATOR DR. KIMBROUGH: Thank you very much.

DR. WILLIAM F. BLAISDELL: I think I was a little bit lucky having arrived on the scene third in line, because Dr. Lyons and Dr. Wilson had obviously prepared the ground and I felt warmly welcomed and swept right into the activities of the hospital when I arrived. I agree with Dr. Lyons' comments about the community; it was a very delightful town, one which I was not aware even existed prior to my visit.

The staff is delightful and friendly and the conferences were interesting and well organized, due to Dr. Evans and Dr. Sargent, because I did notice appreciable participation by the hospital membership in these conferences.

My only comments are the hospital is small enough that I wonder whether economics justify one professor every month or two; and the suggestion to incorporate this as a County Medical Society is a good one, because this would have been my suggestion, I think, had we had an opportunity to participate a little more broadly in the community.

The impact that we have a chance to make in the community is larger if we don't limit it to one tiny hospital with a relatively small staff. That would be my principal comment.

I think the other comment might be that the three-days visit seemed to be a little long. I agree with Dr. MacCarthy's comments that perhaps two days would be sufficient; that is, before the professor runs out of gas and said everything he has to say, and the community runs out of steam trying to get enthusiastic and participation in the session.

MODERATOR DR. KIMBROUGH: Thank you.

Next we will have Dr. Wilson. Incidentally, Dr. Wilson is the gentleman who thought up the idea of Physicians-in-Residence and sold it to Washington. Dr. Wilson.

DR. ROGER H. L. WILSON: Well, I think my comments might be a little more general in a way than my two colleagues.

The choice of Exeter is a geographical one. It is near enough to Visalia, there is some joint staff, it is near Lindsay, Porterville is just beyond, and I noted a number of people from these other communities attended the sessions at Exeter.

This geographical business is, I think, more important than the hospital size. It is actually larger than either of the two hospitals, and a good many patients hospitalized in one wing of the hospital.

As far as I was concerned, I found that on the third day things started happening. The warmup period did seem to be important, but I also found that some of the time was actually spent doing some rather solid work with one or two individuals. For example, working with Dr. Sargent and his colleague on protocols, on how one manages and follows chronic pulmonary patients, working with Sorensen and Dr. Evans on the problem of the post-operative and post-accident high incidence of pneumonitis, atelectasis, and intubation, and things like this; and between us we worked out nine patients on protocol.

The nice thing about it is, though, that plans were put on which I think will be implemented beyond Exeter; that is to say Visalia, Lindsay, and Porterville would involve these units.

I think this geographical approach is good. We did not use the approach that Merced used, that is, the use of two hospitals, because we really wanted to see what happened this other way. If we do indeed go back next year, we hope it will be possible that we will indeed consider it a little more regionally and a little less locally. But I think we discovered the answer to an experiment that consisted....on the choice of fourteen areas in which we felt there were quite different problems falling into three groups: The very small communities with a fair-sized hospital; the middle-sized community with usually two hospitals; and then the larger community, such as Stockton, Reno, where indeed a good deal of organization within the community had already occurred. Because we felt that comparing the problems within these groups and between the groups was a very valid thing to find out if we were going to make a good demonstration project that could be used for a good many people.

I am immensely encouraged by the comment from the Tulare County Medical Society. I think this is the kind of thing that we are hoping, if we do a good job on the demonstration project, other communities in the United States will profit from our experience and, indeed, introduce this.

MODERATOR DR. KIMBROUGH: Next we will hear from Dr. Eugene Bifulco, Chief of Staff Tulare County General Hospital.

DR. EUGENE BIFULCO: Thank you, Dr. Kimbrough.

You have already heard the description of Tulare County, which is a very large area mainly agricultural. We do have a moderate migrant population and the population is growing and the physician population is static if not undergoing attrition, so like all other areas in the country we are in need of physicians.

The hospital of which I am Medical Director is a County hospital, which has been alluded to by the previous speaker. It is a 43-year-old antiquated building onto which in 1955 was added a wooden structure which is very nice, by the way, where we carry on our outpatient department and where we have administration offices.

We also have a small building of 17 beds for pediatric use and total beds in our hospital amount to about 98 beds. The hospital is very well equipped.

I would like to congratulate our Board of Supervisors for not stinting when asked to give us equipment provided we give them a good reason for it and I must say that we are right up to date on our equipment.

Our laboratory is well equipped, so we can take care of the problems that come to our hospital from that standpoint.

In contrast to most hospitals that have been discussed here, our hospital is fully staffed by paid physicians, of which we now have nine. Four of these are either Board certified or Board eligible individuals, two of whom are Board certified surgeons and one of whom not only has his certification in surgery, but is also eligible for thoracic surgery.

We have a pathologist who takes care of the laboratory and oversees the laboratory.

We have two radiologists who read our films twice a day, and the second radiologist aids us in doing regional enterography and enterography externally.

Following the protocol according to the letter sent to us, I found that during this program all the physicians in the area are well disposed to continuing education and the necessity of keeping abreast of the medical innovations.

Physicians also feel that continuing education should be tailord to the needs of the community. In this respect I would like to make a comment here relative to when these individuals come out to give these courses -- whether or not the community of physicians should attempt to get AAGP credit -- because this means quite a bit to the general practitioner.

The reaction of the physicians falls into four categories: enlightenment - and I heard many comments. For instance "I learned something worthwhile. I think this was very good."

Enthusiasm -- we should have more of these sessions and more frequently. I think that Dr. Sargent alluded to this on the outside community physicians.

Pragmatic - many of the physicians said, "I can use what I learned. I think this is extremely important."

And stimulating. "I think it was very stimulating." Physicians have come to me and said, "You know the professor is human. He is like one of us and he has the same problems. Maybe his approach is a little different." They learn something from this.

I think under those four headings this program has been a very marked success.

While the other individuals were speaking here I jotted down some notes. I would like to make some comments relative to some of the things said here and how it affects us.

In our hospital with the nine physicians I have, they cannot leave the hospital very easily, so I have a captive audience and while the Professor-In-Residence is there and we have the program we can go on attending the program for an hour or an hour and a half but we have to get back to our patients and we have a very busy hospital.

These are indigent patients and medical patients who choose to come to our hospital and we are kept quite busy. We see about 3,000 patients in our outpatient department and have an extremely busy emergency room that is manned 24 hours a day by a physician on the premises and this is the only hospital in the whole county that has this setup.

As far as we are concerned for the staff in the hospital we have to budget a time for the program, and another thing that we have to have, I believe, is definite topics. We have to have time to get the topics that we want and three or four months ahead of time so we can talk before a professor is coming out, talk to him, arrange the protocol that we are going to use, and then it will give us time to disseminate this knowledge to the rest of the physicians in the community.

Because the physicians in the hospital cannot get out, I think we have to have a program within our own hospital, but by the same token, we would like to have the community of physicians on the outside participate.

I must say, since we started this program, we have had an increasing number starting to participate and coming to the talks, so that the time element and the budgeted time is extremely important.

One of the things that is particularly interesting about the program is not only do you learn something new but you sometimes put brakes on enthusiasm on something that has been learned or read about and appears in the Journal, and everybody takes hold of it and come to find out it is not as good as they thought it was.

When we get the University impression, we find out that things are not what they are cracked up to be. Relative to this we had Dr. Carbone as one of our Professors-In-Residence and when we talked over the phone about the program, I asked him to find out what the experience at the University of California has been on chemotherapy of tumors of the intestine, cancer of the intestine. I think this was an excellent situation, putting the brakes on it, where many people are treating this thing without perhaps the ultimate knowledge that is necessary.

Some allusion was made here as to cost of hospitalization or what comes of the program mortems. Actually if we can get enough enthusiasm, enough enlightenment to all the physicians, this will ultimately just come to pass. It will just come to pass and we cannot tell within a period of one year how much of this has transpired so that it is going to take time to see the results but the immediate response is apparent from what we hear from the physicians themselves.

Evening meetings are very helpful and the last session we had, we did have an evening meeting that was very, very productive. We had many more of the outside physicians from the outside community come into the hospital to hear the talks.

I feel that the Physicians-In-Residence Program is superb, as far as we are concerned. The physicians warm up to the professor quite quickly, I believe. I think after the first session they started warming up and as they warm up, the program gets better and better. It gets down to the physicians talking man to man and physician to physician which is a far better program than sitting and looking at a television program or listening to a radio. There is no question about it in my mind that this has been a very instructive and productive program.

I think Dr. Wylie brought up the structuring of the program which I think is extremely important. This takes preparation of three or four months ahead of time to get it structured. It is going to also take time over a period of time, as we go along and get some experience, as to how best to do it.

Many of the talks that we had, many of the men came there with pad and pencil and took notes. I think that is indication of the enthusiasm, the enlightenment and the interest that the individuals in the community took in this regard.

Relative to slides and lectures: The men within the hospital and many of the outside men I spoke to found that the lectures with the lantern slide demonstrations were extremely useful they were very helpful.

They found that once the lecture was given and then we could get a patient that we could see or discuss relative to the topic at hand, then many of the men would be referring to what they had seen on the slides and having both the hearing and the visual aspect of this was very very helpful.

I feel personally - and many of the men on my staff feel personally - that a lecture a talk, is just better than just rambling; and, given a few of the basic elements of the topic basic physiology is extremely important in learning the innovations that the professor can talk about, and then the reason for it becomes a little more apparent.

We are very pleased and we would like to have not only more of it but more often.

As Dr. Sargent said we are willing also to participate in paying for this, if it is not continued on a funded basis by the Government.

DR. WILSON: Dr. Kimbrough for the record, AAGP credit is available for people on this basis and counts as University credit basis not staff meeting credit. I don't know whether people used this or not, but it counts as long as they sign in.

DR. BIFULCO: I think this is important for the group out in the county to know. I think we will get more attendance.

MODERATOR DR. KIMBROUGH: Any questions? Suppose we hear now from Dr. Edwin J. Wylie who was a Professor-In-Residence at the Tulare County Hospital.

DR. EDWIN J. WYLIE: First I should say my situation was more fortunate than that of Dr. Lyons coming into the adjacent community, in that having been around the area for some time I got to know a good number of the men in the community, many graduates of the Medical School here; and it was a matter in many cases of renewing old friendships so there was no problem of breaking the ice. It was easy to move right into clinical discussions with the people that are sharing the same problems that you are having here on the service at the University of California.

Most of the men who attended these sessions were very alert and knowledgeable persons who, for the most part, I thought, were very well versed. We were really almost sharing experiences in a sense.

The peculiar eccentric arrangement of this whole county has already been alluded to by Dr. Evans and Dr. Sargent and presents a very unique problem just how to develop a program. It is quite different than Marysville and Redding, where the major hospitals are centered in the major community in the area. Here all the hospitals are quite small, they are all within half an hour, 45-minute driving distance of one another. Each has a distinct problem if it were to sponsor a Professor-In-Residence service where current patient problems were to be discussed as a method of interchange of ideas; the problem being that it is difficult to muster more than an occasional patient.

When you have four or five different varieties of problems in that same anatomic area that ought to be talked about, if the sessions are to be limited to one hospital and if the local community profits more from patient discussions, then we should find out how the physicians like to do this in conversations with people from the University of California.

It is hard for one hospital to depend on the patients; and the question comes up also, is it worthwhile to use more than one hospital to try to get to more people, or to alternate amongst the various ones and draw from four or five, since it is a small geographic area. But it is obviously much more of a problem for the men in the community that are busy, to pick up at noontime and drive 16 to 20 miles and drive back without being over-burdened when they get back.

I am sure this community area is not unique, if we look at all of the Midwest and other areas that might be considering similar types of programs.

If it is to be a matter of straight lecture series (which this was predominantly my experience; it was about an 85% lecture and then informal type with a lot of interruptions and discussion and about 15% patient presentation) then it could be done in one hospital.

It would help a great deal in a community such as this to really alert the County Medical Society for participation so that the patients' cases could be stacked up in advance. Perhaps a physician in one hospital coming to another one to bring two or three cases to start an informal discussion from which then a more formal lecture could be developed and hung on the cases alluded to.

So far as the evening talk and breaking the ice, Dr. Bifulco thought a great deal about how to develope the program, and he was particularly interested in inviting me to sit down for about two hours at the end to interchange some thoughts as to what might be done on subsequent visits.

I gather some of the thoughts both of us developed have been profitable; but certainly for somebody who does not know the community, it would be a great boon to get past that first moment or hour when nobody knows you. They size you up and decide whether they want to stick around or not. They may have had to make that decision a few weeks ago to cancel out an office hour; and perhaps the evening session with the County Medical, with a dinner, might well be the leadoff session, assuming the men get out at night. And then the speaker could show his wares and people can decide whether they want to cancel a few things or say, "Forget it. I will wait until the next meeting." But at least they get a chance in the social session to meet with them and talk with them, and one first evening of this type, I think, would improve considerably the subsequent sessions.

I like the idea of three days. I think the third day things are really warming up a great deal.

This was an eye-opener to me in one sense that I alluded to this morning; that the problems that oftentimes we pass over because we see them day to day in a specialty area we tend not to realize the significance to a man who sees them only once every six months; so that it has changed my attitude a bit as to the manner of presenting material to interns and residents in the fourth year medical school.

To me this was a very profitable session and I would like to be involved in many more.

DR. WILSON: If we do indeed continue this program, you are thinking of the same people to go back to the same community?

DR. WYLIE: The same person who was there before, was there three days; and I told them absolutely everything I know about vascular surgery. It will be at least ten years before I can tell them anything else.

DR. JOHN V. CARBONE: I would like to echo some of the things Dr. Wylie said. I had a very fine time in Tulare. I was very favorably impressed by the enthusiasm for continuing education; and the men in a community like this, where they are working very hard, for them to take time away from their busy schedules to listen to some of the sessions, and particularly in the evening session, to stay around late and discuss their problems with me, have been very profitable.

I think one of the important reasons that I consider the success of the three days that I was there was in the preparation. Dr. Bifulco had called me. I discussed with him what in particular he felt that the members of the medical community would like to hear from me. We modified the program into its final form and I think this, in a large part, enabled me to know ahead of time the material that I could present and feel that it would be reasonably valuable to the members of the group.

One of the problems a man from a university has to face when he goes into a community of this type is the fact that he is going to have a varied audience. I think in large part the success of these sessions will depend upon the man organizing it from the other end. He has to know the problems of general interest in the community. For example, I felt that our discussions on hepatitis and prophylaxis of jaundice, et cetera, had been worked out because the members of the medical community down there had a keen interest in this. This was probably valuable because the men in that medical community wanted to hear about it.

I think we have to find ways of involving the medical community more actively. We had a pleasant dinner with Dr. Sargent, Dr. Evans, Dr. Bifulco, Dr. June and others and these are a very aggressive bunch of physicians down there who are involved in their community. I feel that the reason for Tulare's enthusiasm is in no small part due to these men who are most anxious to continue this program of education in their community; and I think that the physicians, and particularly the community of patients will profit by this tremendously.

In summary, I felt that the three days were very valuable. I felt that I still could have said a few more things but people were too busy down there and they had to go back to work. I would be very happy to continue to participate in this program. It makes one feel rather good to feel that one may have contributed a little bit to this process of continuing education in the community.

MODERATOR DR. KIMBROUGH: Thank you. Are there any questions?

DR. MacARTHY: I would like to ask if the suggestion about having an evening dinner to get everybody off on the informal right foot might be an alternative. Two days plus an evening. I would like to throw that out and hear some other comments on that as an alternative to three days.

MODERATOR DR. KIMBROUGH: I think that will come up in our open forum after we have heard from the other three hospitals.

(Coffee break)

* * *

MODERATOR DR. KIMBROUGH: We will next hear from Dr. David E. Bushman, Director of Medical Education, Watsonville Community Hospital.

DR. DAVID E. BUSHMAN: Watsonville is a rural community that is located in the middle of the area between Santa Cruz and Monterey on Monterey Bay. Santa Cruz is on the northern tip of the Bay and the Monterey area is on the southern tip.

We have about fourteen to fifteen thousand people in Watsonville proper. The city is located on the southern boundary of the Santa Cruz County and across the river is another small area; and immediately adjacent to Watsonville on the northern part of the city there is another small area, so that the hospital service area is probably about 35,000 people.

The community is rural and produces a lot of apples and lettuce and other field crops.

We have about 40 members of the active staff on the hospital. Our present hospital is approximately 30 years old and we are engaged at present in the construction of a new hospital, which is probably close to about 90% complete, and we will probably be moving in the next two or three months.

We have at present 86 beds, which we will expand to around 102, but very shortly we will probably expand that by another 45 or 50 beds.

The continuing education aspect really started just recently, as far as our hospital is concerned. We are close enough to the city to participate in the regularly planned post-graduate courses that are offered at the University of California, Stanford and the Pacific Medical Center, and have been doing this . . . but it became apparent that this was getting increasingly more difficult . . . because of the time involved being away from the office and sometimes expenses involved.

In the middle of this past year we organized a committee to look into the aspects of developing a program . . . one that would allow us to have physicians from teaching institutions to come to our area and our hospital, but would also allow us to participate more on an individual basis at one or more of the teaching institutions in the Bay Area.

One of the problems, as you all know, about attending post-graduate courses is that many physicians congregate in a large room and you spend one to five or six days listening to different lectures and if you suddenly realize you would like to participate in that program and look it up in the bulletin and find out it has just passed, you have to wait an entire year until it comes around next time.

So we wanted to develop some kind of continuing education program that would allow us to come to the city and the hospitals at that time that was more convenient for us, and hope that we could make arrangements so this could be done.

We have had discussions with other hospitals, other teaching institutions, and one of these was with the University of California, the present program that we are talking about. We have only participated in one, and the first one for us was in December of this last year, but the attitude of physicians in our area is really very good as far as their interest in continuing education.

We have probably 26 or 27 physicians that practice in Watsonville. About half of those are general practitioners, and during the recent program we had in December, we had probably at least a 70% representation most of the time.

The reactions of the physicians toward the session have all been good. We have a little questionnaire that has been sent around and the results have all been praise, and everybody is interested in participating in other programs that we hope will be available.

As far as the appraisals of accomplishment are concerned, it is probably too early for us to know about the results of this program. Our first program was planned in advance; we also had another application-questionnaire that we sent to members of the staff, and asked them what they wanted to hear. We felt that this program offered by the University of California for three days, three or four times a year, could be best utilized if we have a broad topic of discussion which would be of interest to all the physicians, or nearly all the physicians, on the staff.

We also found out that it would be advantageous to us to possibly have a visiting physician from a teaching institution to come down for a period of less than three days, and that at that time the topics under discussion could be of a more narrowed nature and would not necessarily have to involve every member of the staff. If so, that this sort of a program might come more frequently than three times a year.

We got together with Dr. Kimbrough and his staff early and decided that our first discussion would be on infectious diseases, the methods of diagnosis and treatment, and this had to do with viruses, and treatment in the hospital and out of the hospital.

We had two physicians for our first meeting. I don't think it was originally planned, but due to an unavoidable set of circumstances, we had two, and we all thought that one physician would probably be better rather than more than one. There was a duplication of information and the two did not have a chance to discuss fully beforehand what they were going to talk about, and both physicians felt that they would rather have had just one also. They felt that maybe they would forget something and would expect the other physician to say it. Anyway, they also felt that one physician would be better than two.

We were very fortunate. We had Dr. Richard Leonards the first two days and Dr. Moses Grossman who came the third day. They were very well received right from the beginning. There was no feeling of animosity or anything of that nature.

Dr. Leonards spoke to us about some of the aspects of viral infections. As I was saying earlier, it is difficult to talk about the accomplishment of the program, but after this meeting on December 13, 14 and 15, we had a tremendous increase in the number of viral infections in the last six weeks. Whether this is due to transfer of San Francisco viruses or not is hard to say.

I also asked Dr. Standage, who is here, one of the pathologists on the committee, if he had any comments as far as the accomplishments of the program were concerned, and he reminded me that since the middle of December we have had not one death from smallpox. Dr. Standage did say that there has been a decrease in the amount of probably unnecessary laboratory work that has been asked for by physicians since this meeting, so this may be some accomplishment.

Our committee has talked about the need for physicians in the area and we feel that there are several things that have been important. These things that could be supplied by the visiting physician from the teaching institution. One of these is that we feel that the visiting instructors or professors could be of help to us in just a general review of the basic material of the practical core of the practical aspects of medicine as far as approaches to diagnosis and treatment.

We also felt that they could serve a purpose by supplying us with any supplemental knowledge as far as current changes or additions in the same aspect of diagnosis and treatment.

We felt that they may also be able to give us information, and summarize the more important information that appears in the myriad of journals that most of us don't get a chance to see or read.

We also felt that the program of continuing education would be of benefit to us, if it were possible for any one of us as individual physicians to participate in a program of continuing education at one of the institutions for a period of time, possibly a day or possibly a week, or possibly a month in any particular specialty that he might have an interest in.

We also felt that we might be able to get some help as far as libraries were concerned. Our library is behind in everything and it is difficult for a small hospital to have all of the information, all the journals available. Organization of a library, or at least association with institutions that have libraries, would be of some help.

I think that is all I have.

Dr. Standage, did you have anything that you would like to add to this?

DR. HARLOW D. STANDAGE: I don't believe so.

DR. WILSON: Might I just make one point? The title of the program was very deliberately chosen as not Professors-In-Residence nor Instructors-In-Residence, but "Physicians-In-Residence." I think the interplay between two apparently separate groups of physicians bears this out.

MODERATOR DR. KIMBROUGH: Dr. Leeds, would you like to discuss your trip to Ukiah?

DR. FRANK H. LEEDS: I am afraid my experience pretty well duplicates so much of what has been said here, so I don't think it would be wise to go into details. I was somewhat in the position of Dr. Wylie, that I knew the group there very well, and I was quite at home with them.

I think the only thing different from my experience that may reflect somewhat of what the last speaker was asking is that I had several ask me what were the opportunities for them to come down to the University here for actual involvement in the training program at the University. I invited them to come on down. I outlined for them some of the programs in my special field that were going on, Dr. Blaisdell's rounds on Tuesday afternoon and Dr. Wylie's rounds at the University on Wednesday, and I know of at least three who have been here for at least three or four times. One of them actually took a week off from his practice and came down and followed me around the hospital, made rounds with me, went to my office with me and watched me examine and test patients and evaluate them, and scrubbed with me on at least four major operations.

This to me was very useful. I thought it was a complement of the three days I had spent with him up in his own hospital making rounds with him.

MODERATOR DR. KIMBROUGH: Thank you.

(The following remarks were submitted by Dr. William A. Todd, Jr., Assistant Director of Medical Services of Scenic General Hospital of Modesto.)

"Modesto, county seat of Stanislaus County, is situated at the northern tip of the San Joaquin Valley, 93 miles southeast of San Francisco. There are approximately 230 industries in Stanislaus County, about 75% in the Modesto area. Manufacturing is the third largest employing group, following agriculture and trade. The expansion and diversification of industry in the area has seen manufacturing payrolls increase from $15,502,000 in 1950 to $70,500,000 in 1966.

"Scenic General Hospital is a community hospital, operated by Stanislaus County: 292 licensed beds, 189 acute medical-surgical beds; a general hospital offering services in most of the specialties of medicine. There is a General Practice Residencey Training Program being allotted seven spaces (six are filled); also there is a Surgical Resident from an affiliated program, in the 3rd or 4th year of training, rotating at the end of six months.

"Average census past year, 149.

"Teaching staff consists of 105 members, all from the county. Except for the G.P.'s Staff members, all are either Board eligible or Board qualified.

"The emergency and trauma service is exceedingly active, as most of the more serious accident cases arrive here.

"A modern and up-to-date Radiology Department is under the supervision of Radiologists of the community, in rotation.

"Laboratory facilities are available 24 hours a day (on-call basis after normal duty hours). Practically all of the required tests are accomplished locally.

"The Medical Library in the hospital (3,056 volumes) is available to all physicians of the county and receives 51 journals from County Medical Society (108 journals are subscribed to with an active program for updating text and reference books).

"The speakers, under Physicians-In-Residence program, were well received by those physicians attending.

"The program dealing basically with Endocrinology (Dr. Di Raimondo) evoked lively discussion and many pearls were gleaned. These sessions were:

"Gynecology Conference (Discussion of Complications of the Pill. Presentation of Endocrine Problems in Gynecological Patients)
Medical and Pediatric Ward Rounds - Discussion on Diabetes

Informal Discussion
Presentation of Problem Cases
Surgical Chest Presentation
Chest Clinic

T. B. Ward Rounds
C. P. C. with discussion by Dr. Di Raimondo
Case Presentation - Retroperitoneal Fibrosis
Case Presentation - Endocrinology Problems - Adrenal and Pituitary
Endocrine Problem Cases.

"The attendance included physicians from all phases of medicine, although the numbers were relatively small, those who attended were rewarded for their effort.

"The program by Dr. Blacker:

Discussion of the mechanics of commitments followed by ward rounds
Lecture on Community Health Centers
Consultations in Child Psychiatry
Discussion of Hypnosis in General Practice
Individual interviews
Lecture in Group Therapy
Consultations with local practitioners
Lecture - Use and Abuse of Tranquilizers

"This program had a narrower field of appeal to the physicians but again, those who attended were enthusiastic and much lively discussion was generated. This program was particularly beneficial to the house staff, especially in the approach to the so-called "crock" with psychosomatic manifestations.

"The various specialty groups in the community are actively pursuing some form of continuing education. We are very fortunate to be close to a wealth of educational material and these programs are being taken advantage of. As with any community, time has become a precious item and to attract large numbers of doctors during the week is not easily accomplished. Many feel they can pick a program and get more from it away from home as they are not confronted with frequent calls.

"The house staff cannot get away as freely so they cannot be exposed to too many programs of this nature."

MODERATOR DR. KIMBROUGH: I think our last one on the program today is Dr. Robert J. Barnet, Chairman of the Program Committee, Reno, Washoe Medical Center.

DR. BARNET: I think Reno is familiar to most of you, at least by reputation. It is approximately 225 miles northeast of San Francisco. The Reno-Sparks area has a population of approximately 150,000, so it makes it different from the communities that you have heard of so far in size, first of all.

It has a drawing area of approximately three to four hundred thousand, plus several million tourists every year. It draws from most of Northern Nevada and the eastern slopes of the Sierras and part of California and Lake Tahoe.

There are four hospitals in Reno. Washoe Medical Center, which is currently 415 beds and which this summer will begin construction to expand to 765 beds: has approximately 3,000 emergency room visits per month.

St. Mary's Hospital has approximately 250 beds.

Veterans Hospital is about the same size.

There is a State Mental Hospital with about a thousand beds.

We do not have a house staff. The emergency room is staffed by paid physicians on a 24-hour basis, and these physicians are often individuals who either plan on going into practice in the community or have not been employed there and decide to do so.

Through a recruitment program we have been able to maintain an adequate level, more adequate than many places, of physicians.

We have selectively employed people in the emergency room that we would hope to go into practice, and we have landed in the last couple of years primarily general practitioners, so in the last two years we picked up approximately six or eight new young general practitioners who have gone into practice.

We depend a great deal on the nursing staff for such things as cardiac arrest and coronary care facility. The only lack we really have in the community is some more sophisticated tests, such as cardiac catheterization, more sophisticated pulmonary function testing, and certain speicalized surgical procedures and cardiac surgery.

In some ways we are very similar to Merced, in that we have effectively one medical community. There are approximately 155 physicians in active practice in town. Approximately 150 of these are on the staff of both hospitals. Thirty men in general practice, 16 in general surgery, 17 in internal medicine, 10 in orthopedics.

We have a past history of active continuing education, having weekly Grand Rounds approximately 80% of the weeks of the year.

We have had some two and three-day programs in coronary care two and three years ago. The AAGP has an annual program, as does the Cancer Society. Reno Surgical

Society meets one night a month, usually with a medical program, and the out-of-town speaker often remains the following morning for grand rounds.

We have had three speakers in Physicians-In-Residence and the first one in June was Dr. Crowther, a neurologist; the second one was Dr. Murray from the Department of Orthopedics in September; and Dr. Kardos, who is a clinical neurologist, was there.

The first program we picked because we thought it was a review of the program we had in the past several years and needed additional attention.

We asked Dr. Murray to come because we hoped to interest some of the surgeons in more active participation in continuing education, and he was really the orthopedist.

The third speaker was chosen as an individual who might be able to appeal to a broad spectrum of the staff, and this third program, I think, was the most successful, primarily because we had an opportunity to develop some experience in programs, and it was arranged a bit differently in that we had three morning grand rounds, which were of general appeal. And having a relatively large staff, we were able to then have some clinical department meetings, so we had a Department of Medicine, Department of Ob-Gyn, and a Pediatrics meeting at noon at lunch; and in two instances they were presented by the Department, and a surgery meeting in the evening.

We have, as I said before, combined this type of program with the County Society, the Reno Surgical Society meetings, and have them stay on for rounds in the hospital.

I think this approach in Reno has been very successful.

Reactions of the physicians attending the sessions -- I don't think we heard any adverse response. There is certainly some indifference, as one would expect.

The first two speakers were selected with the understanding that there would be relatively limited attendance. Dr. Crowther's program was planned so that people from school systems and psychologists and others could attend. I think the comments we did get were uniformly positive, even from some people that ordinarily had not been enthusiastic about this type of program before. For instance, the orthopedists, all of those who answered, were very strongly in favor of the program.

The problem of time, some of the people felt that this might be a little long, but I think with a relatively large medical community and picking someone who can appeal to the different groups within the community, three days is certainly not too long.

We did have some problems and I left that off your list of comments that you wanted: One of them was the problem of advanced scheduling. Dr. Crowther was the first one who attended, and I think he suffered from this particularly; and also, I think, because we had-for not our reasons, but his - to change the date about two weeks ahead of time. We planned on school being in session and it was out, and this created a problem; and I do think we need several months because many of the people operate to the point where they are scheduled often a month or two ahead of time.

The other problem that we had, since no one was as familiar with the faculty, as perhaps some of the others might be closer to San Francisco, we really did not know whom we wanted because we did not know that much about what the overall faculty was like. We certainly knew some people by reputation and by having heard them speak at other meetings; but we felt if we had had a list of the individuals, some type of recap who they were, what their areas of interest were, what topics they might speak on, it would have made it a little easier for us to select the speaker that we thought would supplement our program the best.

As far as what it accomplished -- first of all, I think it made many physicians aware of the problems they might encounter. Certainly this is difficult to measure.

I am sure that an awareness of some of the problems that physicians might be creating or would encounter would increase morbidity and mortality, but I am not sure it is measurable.

Secondly, there have been some obvious changes in drug use, tests which are difficult to document.

Third, we have arranged for the publication of certain data that Dr. Kardos presented, and distributed to the staff.

Fourthly, I think the success of the program - and I feel it has been successful - will help us to justify local funding for continuation of this kind of program.

As far as needs and type of approach, I made a few comments on some of the things we covered. We were tied into the radio program down here at one time but are not currently, because the participation in it, I am sorry to say, Dr. Kimbrough is about nil.

This may be my personal bias, but I think as far as the major teaching aid, closed circuit television, has limited usefulness. Set types of programs prepackaged, we have had some experience with this, and as far as the tutor tapes in cardiac arrhythmias, we have used it some and expected it to be more accepted by the nurses, but, in fact, it has not been. And again we are faced with the problem of required manpower and face-to-face confrontation put the thing over.

I think the approaches that Dr. Goodman McGregor pointed out are the type of things that I can see as being successful, at least in our area.

One modification of the visiting professor program that we have wondered about its usefulness, is more senior house staff from the University, such as the second year residents who conceivably could stay for longer periods of time, at least in the specialties, and would have a great deal to offer to some communities and might well involve a lesser problem in funding than this type of program.

We did include paramedical personnel in our plans for the first conference. We did not for the others, I think in part because we wanted to give the visitors a chance to enjoy the community a little bit.

As far as more than one person attending, I think we have a hard enough time finding programs that we can get people to for one individual at one time. I think the idea of some type of paper handouts to go along with some of the talks is very useful.

Although we enjoyed the speakers who came, I think we would rather have some different people, since we have some particular problems that I think we might want to select rather than the very same people coming back each time.

As far as the faculty, I think this is a challenge to them to come up with a program that is going to provide appeal to the individual in practice. And as we did with the last program, I think there is a challenge to the visiting physician to come up with topics that he can present to various segments of the medical community, whether they be surgeons, interns, or what-have-you. I think there is some thought on the part of the faculty that they might well be able to suggest topics that could have appeal not only broadly but to smaller groups of the broad medical community.

MODERATOR DR. KIMBROUGH: Thank you, Dr. Barnet. Are there any questions?

DR. CROWTHER: I would like to second the feeling of my colleagues that I enjoyed my visit very much.

Being a neurologist is a little different, as Dr. Barnet was saying; it appeals to a limited number of the community. Dr. Peterman, who is the only medical neurologist in the city, and I decided that we would select subjects which had as broad an appeal as possible, even if it meant including paramedical personnel.

One of the subjects we selected was the problem of learning disorders in schools, into which the medical communities have been drawn, whether they want to or not, particularly the pediatric community, and if they are available, the neurologic community. We did this because the State of California has for the past five years expanded its program in this area. It is a problem area and Reno in particular was having problems in establishing programs that we felt needed discussion on some of the difficulties that children were having in diagnosis and treatment.

The second subject was one that we felt had broad community implications in terms of clinicity, and that was the subject of epilepsy. At the University, of course, we have a program now in community investigation of epilepsy, so we felt that this, too, would be an appropriate subject to introduce before a broad audience.

I must say in terms of the school discussion that we had . . . that it was a very popular one, although I suddenly realized that I was in the middle of a feud locally. But we had a very profitable experience and I felt that the smaller meetings in which there was a closer give-and-take were probably better than formalized lectures, where you could disseminate the information but not get the give-and-take in the same way as in a small group.

One of the problems, as I saw it, was that the people who graciously took me around the various hospitals not infrequently happened to be members of my own specialty, so I found myself examining very interesting neurological cases with a neurologist, and wishing the discussion of these cases would be taken by a member of the medical community, the internists or pediatricians. But I recognize that the physicians, of course, are very busy and this is, I believe, quite unavoidable.

I don't know about the length of time that the program should be. If we had compressed my time, probably I could have done as much in two days as I did in three, but I will say as far as Reno is concerned and the safety of one's pocket, that the shortest number of evenings spent there, the better for it. Thank you.

MODERATOR DR. KIMBROUGH: ...Dr. Victor Richards was a Physician-In-Residence in Stockton. I think the Director of Medical Education was unable to make it, so Dr. Richards will comment on his trip.

DR. VICTOR RICHARDS: I had a very enjoyable three days in Stockton and I was very pleased to read this group of letters about the Stockton experience because there are some heart-warming notes which I will come to later, a little embarrassing but I enjoy reading them.

I will read the comments from the doctor in charge there. He starts with the usual regrets at not being able to come here, and then it goes: "From my own standpoint" -- This is the first letter from Dr. Bernard who was Chairman of the Continuing Education Committee at the San Joaquin County Medical Society -- "I have been quite pleased with the over-all results of the three meetings we have had. It is obvious to me that the logical place to continue medical education for our community physicians is at San Joaquin General Hospital, but because of certain local factors, this has been extremely unsuccessful. The physicians in the community will not come to this hospital and, therefore, another approach is needed. The only approach I can see feasible is the one used for these three meetings. We certainly would have appreciated much better attendance, but half a loaf is better than no loaf at all, and a group of interested physicians was on hand to listen to each of the speakers at each session. The size of the groups varied but I personally believe that the money spent by the Government for the purpose of this program was no doubt the best spent money the Federal Government used this last year."

They had their meetings at the local County Medical Society, which is a beautiful building right across the street from the hospital in the center of town, where it was close to the doctors' base of activities and a very pleasant place to meet, and very adequate in every way. We were served lunch, had coffee breaks and excellent facilities.

Attendance was pretty good. There must have been 75 to 100 doctors there all the three days that I was there.

> "Furthermore, since this approach is the only reasonable approach to continuing education that I have run across, I heartily endorse it and regret the program has come to a close. It would be my considered recommendation that this approach to community physicians' education be continued and developed."
>
> "The only real solution to continuing education is for the physician to take so many months off each year and re-enter a medical center training program as a preceptor in his chosen area of work. This has not been feasible except in rare instances under the present setup. It has been suggested by Dr. Saul Robinson in a recent editorial in the CMA Journal that the physicians be subsidized for these training efforts. I would agree with Dr. Robinson that this may be a reasonable approach and would seem to be a potentially valuable area to investigate."
>
> "The millions of dollars available through our regional medical programs can only be effective if used in the continuing education of the physicians and paramedical personnel. At present there seem few other avenues of approach to the solution of this problem.

"I hope the above comments will help. I am as frustrated in this areas as anyone, and hope some useful results come out of the meeting.

Sincerely yours,

J. David Bernard.

"P.S. I have enclosed similar letters from the Chairmen of the various meetings.

The next letter is from Dr. Robert F. Nejedly, and reads as follows:

"Dear Dr. Bernard:

"On December 18 and 19, 1968, Dr. Peter Forsham conducted a Professor in Residence program at St. Joseph's Hospital and San Joaquin General Hospital. The topics covered various aspects of diagnosis, treatment and pathophysiology of endocrine disorders. Participation by the members of the medical staff at St. Joseph's Hospital and the Residents-Intern staff of the San Joaquin General Hospital was excellent.

"This type of program, in my estimation, is one which provided us with a maximum amount of useful information in the minimum amount of time expended. Comments from the doctors attending seconded this impression.

"There was general disappointment expressed when it was learned that this program is to be discontinued. Some suggested that the medical society investigate means of funding such a program locally and that an attempt be made to work out some format in which the university would provide us with teachers necessary for such an undertaking.

"May I express my thanks to you for your help in making this program such a success."

This letter is from Dr. de L'Arbre and addressed to Dr. Bernard.

"Dear Dr. Bernard:

"The Professor in Residence program, sponsored by the University of California Continuing Education Committee, took place on Thursday, Friday and Saturday, September 19, 20 and 21, 1968 with the presence of Dr. Victor Richards and was sponsored by the Surgical Department of Dameron Hospital.

"The presence of Dr. Richards in Stockton for those two and one half days cannot be classified in any other way but a complete success. Dr. Richards' broad knowledge, easygoing manner and cooperation was the single most important factor in this success. Participation from the specialty groups, as well as from general practitioners, was excellent. The sessions were extremely well attended, with never less than 50 physicians present. The format used was well received. It consisted of subjects of broad interest, introduced by one of the local physicians,

> with an opportunity for Dr. Richards to speak on the problem and ample time for question and answer periods. Presentations of difficult cases of broad interest was likewise well received, as was the final pathology session on Saturday morning. It is hoped that the University of California will be able to continue the program since it reached many of the physicians who might not otherwise take the time to attend out-of-town meetings."

I certainly agree that one thing the physicians liked about this is that they do it in their home town . . . (also). . . the meetings were held from about 9:00 in the morning until four or five in the evening. This let them do their hospital rounds in the morning, gave them a little break at noon, and they were able to pick up their calls and keep up their minimal required work without having to arrange to be away and spend the day in the meetings. So I think they liked it from the standpoint of being educated in a home environment. They liked the idea of having local people in the community arrange a session of the program and chair it, so that the local conference felt that they were participating. They liked the idea of trying to have ample time available throughout the day for questions and answers, and then they had case presentations that a member of the community could participate in, and if he wished to, he could bring a case for case discussions.

Actually, there was close contact for a three-day period of about 75 to 100 physicians in the area, and one physician in residence.

(Short recess.)

MODERATOR DR. KIMBROUGH: We now come to the Open Forum where we will listen to your recommendations or your criticisms. We hope you will be as candid as possible. We will first hear from Mr. Tucker from HEW, Arlington, Virginia.

MR. TUCKER: Thank you, Dr. Kimbrough, for ascribing to my request to be first at the open forum program.

I have been sitting over here with my two antennas very erect and pulling over in that direction, because, among other things, I have a Doctor of Divinity Degree, so at the lectern and this microphone it is magnetic and pulls me over--I want to get up and say something.

I recall in the several hundred sermons I have given, it is a rare circumstance to see an M.D. in the audience, and to capture thirty of you around the table--I am going to be homelitic, because I wouldn't resist using this opportunity.

I bring in this different entity bit because in all seriousness I think we should have a session of prayer. I hear about the physicians that have a hundred cases that you are going to have to take care of because you are away for the day, and I see twenty physicians, and I think we really ought to pray for the 2,000 people who did not get treated today.

It is very gratifying to me to be at this meeting, because my memory goes back many moons ago, and Roger Wilson and I sat in his little office and kicked this whole subject around from stem to stern, from top to bottom, and I recall Jerry and I going back and fighting the battle of the budget to get the program started--so it is indeed, and it should be, I am sure, to Roger a very gratifying occasion to see this meeting come to fruition as a result of these efforts.

I am also gratified because as I sat there and heard about the beautiful places in California, especially this Exeter that is supposed to be Paradise, maybe I will come here and have my prostatectomy or hemorrhoidectomy, or whatever an old man like me is to have.

At a meeting like this one gets to the seat of the problem, and this open forum will bring out those problems that have confronted you and, hopefully, will arm both Dr. Kaplan and myself to go back and present your case once again to the powers that hold the purse strings, in hoping that we can go on for another year.

I think that a great deal of credit, congratulations, should go to Dr. Wilson, Dr. Farber, Dr. Kimbrough, and whoever else selected the physicians to go out in residence. I am very much impressed by the fact that each of these men, as well as having expertise in his own field, was certainly a psychologist in meeting different situations, confronting these situations, and in many cases turning havoc into a successful adventure--so I do hereby congratulate you on the selection of the physicians who went out in residence and have really made this program the success that it obviously has been by virtue of the comments that each of you have made.

Prior to my coming into the Public Health Service, I was a city manager in three cities and I learned to become very provocative by innovating subject matter which normally would not be brought into focus, such as moonshining, numbers, prostitution, even money I brought into many discussions, and that is what I am going to do this afternoon in opening this forum by being the devil's advocate once again and bring up this business of money.

I would like to do it by presenting to you a hypothetical case and then let you discuss it as part of the open forum. Supposing that we are successful in supporting this program financially for another year, and you know now that this was going to be the case. Remember this is hypothetical. I am not promising anything. At the end of the second year, based upon what Dr. Evans interjected into this meeting, could you or would you become financially self-sustaining?

Give Dr. Kaplan and I the answer to that question and I think we can be of great assistance to you.

The second problem with money which was mentioned at the very beginning of the session but has not been alluded to very much since is, "Can we show where dollars have been saved?" Someone mentioned that there were lab tests, so there was a saving of money. Perhaps you did not have this in mind or perhaps you can't do it, but if you can, certainly give us this kind of information to take back with us and think about it and bring it out in the open forum.

If we do support you for another year, certainly do it next year, so that if we have a meeting--and I hope we would a year from now, such as this--we will have those documented and ready to put on the sheet of paper that goes to the Congressmen and budget people to help other areas get this type of a program under way, if it is a success, which you apparently have indicated that it is.

DR. KAPLAN: I feel like one of the visiting professors--I should not say "professor"; I will get shot for that--visiting physicians--because I really have learned a lot today.

We sit up on the twelfth floor, my office overlooks Washington, I have a beautiful view and I can see the Congress and all the monuments, and we get up there and think about ideas, and ideas come across our heads and we say they are wonderful ideas; let's try them out and see what happens--but it is not until we come to a meeting like this until we get the feel of what is going on and learn a lot more.

It has been a very gratifying experience to me and I certainly feel that we have spent federal dollars in a way that one can be proud of, either as a taxpayer or as an administrator of those dollars.

I wish that more of the federal dollars were spent that way. I think all of our taxes might be less.....

There are a couple of things I noted here. One, you talked about libraries and the need for doing something with this, and I would like to bring to you a concept that has now been developed as an outgrowth of another one of our contracts. It is called the Core Library Concept, in which the physicians in a community hospital, in looking at their library and looking at the books and how they gather dust and how a lot of the pages have been yellowed, decide that they need to do something with their library. In doing this, they went to each department and said, "Pick one book that you feel would be the most helpful in your field to a non-specialist in your area, and this is the book that we will buy for the library."

In doing this, they came up with a series of books, and if you want to get the list, you write to Norman Stearns at the Post-Graduate Medical Institute at Boston. But I think the greatest value of it, is doing it yourself and finding those books which you feel individually would be best suited for your hospital.

In addition to this core library, what they have done, on the front flap of each book they have listed consultants, all the consultants in the area who would be available to discuss with the physician who is reading the book problems in that specialty. And not only do they list a name, but the phone number, and this apparently has been a very successful way of getting the practicing physician who knows nothing about ENT, for instance, to read a little something about it and find somebody who he can talk to and talk about it, and apparently the cost has been very minimal as compared to a number of other ways of getting information to the physicians.

I just bring this out to you. I believe there will be an article in the New England Journal in the next few months detailing this further, but this is one way of upgrading and building a library that can be useful to the physician.

Another thing that I would like to point out to you, I think Dr. Barnet mentioned the need for fellows in a community hospital to help along the program on a long-term basis.

We have, in our efforts in the Division of Physician Manpower, attempted to look at community hospitals and see how they can be utilized not only for continuing education but for the teaching of medical students. In an effort to do this, we have come up with four ideas, three of which are in contract form, and the fourth one is now under study to develop the criteria for selected hospitals for medical students.

The first is with the Post-Graduate Medical Institute, in which they have gone to forty hospitals and offered consultation in the way to improve continuing education activities within the hospital. They are not putting on continuing education programs themselves, and they are not providing Physicians-in-Residence, but they are attempting to help the hospital help themselves, and this type of approach has been very useful and very effective. In fact, they got forty control hospitals that are now clamoring to get into the system, and they won't let them get in because they will ruin the study, but at the end of the contract I hope they will go into the other hospitals.

We have our Physicians-in-Residence program; and since July 1 of this past year we have a program we call "Fellows-in-Residence" at Yale Medical School, in which Fellows in gastroenterology spend three months in community hospitals doing their residencies, but also acting as consultants to the local physicians on gastrointestinal problems.

From our first feelings from this, it seems to be quite a successful program and hopefully we will have a meeting such as this with the community hospitals to find out its value in continuing education.

Lastly, of course, we are trying to develop criteria for the utilization of community hospitals for the teaching of medical students, with the idea being that we would have a full-time faculty member from the medical school in the community hospital, and utilize the practicing physicians to teach the medical students; and the medical students would act as stimulus to the practicing physician to continue his own education by asking all sorts of embarrassing questions, and these would hopefully stimulate the physician to go and do some reading.

So these are some of things we are doing.

MODERATOR DR. KIMBROUGH: We are now open for comments.

DR. EUGENE BIFULCO: What we are doing is helping the patient, reducing tests; that is one thing, but by increasing tests we are also helping the patient. It may be more expensive but the ultimate is to help the patient, so this in itself should not be a goal.

MR. TUCKER: If we have given you the opinion that we are interested more in dollars than patient care, you can forget it. If you have given better patient care that obviates dollars, because this is our ultimate goal. We are assuming you are giving us these experiences where better patient care has resulted. We are also stressing where you give us the dollar savings, we need that as well.

DR. KAPLAN: The measurement of quality of patient care is an extremely difficult thing to do. Nobody has done it yet on a quantitative-qualitative basis, and if we can take things that are such as reducing laboratory costs or unnecessary costs, we can assume they will lead to better patient care; or reducing the amount of operations that are done on a questionable basis.

If we can show quantitative changes, we can assume this leads to better patient care.

DR. BIFULCO: This is just as difficult as saying we have a body of knowledge and a group of physicians and....the group has no stimulus from the outside; but then all of a sudden we have the stimulation from the outside, these patients treated by these doctors are going to get better treatment, and it may even cost more, but the patient is the only yardstick we have.

DR. KAPLAN: All right, demonstrate it to us in quantitative terms how we get better patient care. This is the prime aim of continuing education, regardless of cost; but for us to go to Congress and say, "Give us more money," they are going to say, "Show us what you have done." And if we come up with a lot of platitudes, they can't grasp it.

How do we judge when a patient comes to you and you charge him seven dollars for an office visit? He has got nothing tangible to put his hand on. You know you gave him the best possible care; but when he spends seven dollars for a tankful of gasoline, he has a tankful of gasoline and he can show that, but you cannot show good patient care, and this is the problem we have. We have got to have something that we can show.

It is a rotten way of doing this, but it is the only way at the present time and we have to go ahead and do this. How can we demonstrate better patient care through continuing education?

FROM THE FLOOR: The question that I have--and I allude to my own proposition--we assume at least in the previous rounds that most of these Physicians-in-Residence have been approximately three days per session per location. It would be of interest, at least to our Medical Society and our hospital staffs, to have some idea: what is the figured cost for this amount of time, assuming that we were able to come up with it? If I go back to my medical society and say, "Look, it is costing the University, X number of dollars to put them out three days, this is their salaries, all the fringe benefits, expenses," then I could say to my society, "We have some funds in our society for continuing education," and I can go to the hospital staffs and we have money, each of our staffs, for library, for continuing education, and for lecturers. How much of this money, then, can we put back in a check to the University, assuming that the University is going to be paying these people's salaries? It would be difficult for us to make out checks individually to each man. It could be done, but it would be simpler if we can channel our monies to the University.

My society and the hospital staff want to know how much this is costing. This is their first answer, and then the decision is, "Can we afford it or can we afford to share it?" This is at least food for thought.

The other thing, I sat here and did a little figuring. During our two sessions of three days, I figured that we received 420 hours of instruction for nurses and paramedical staff people, and we received in our three locations 360 hours of instruction to our physicians.

Now, if you turn this around into dollars, the physicians in our area figure when they are in their office they ought to be making a gross income of $30.00 an hour, give or take a few dollars. The nursing staff, at least in the hospital, figure that the overall gross income reflected on the nursing staff should be near $10.00 an hour. This brings two figures for the physicians' time that the physicians are contributing to this continued education to approximately $10,800 of their income which they did not receive while they were going to school, and $4,200 that the nursing staff was paid by hospitals while they were going to school.

This brings our total for six days in our community to a contribution of approximately $15,000 for our education for six individual days already, without the fact of adding a cost for the man coming to the community. We don't object to this. We are willing to spend this money readily, but the other question then is, "How much will go out for the extra fringe benefits and the extra bookkeeping?" If we can finance this all ourselves to the University, how much would a fair figure be for a man for three days?

MODERATOR DR. KIMBROUGH: That is a difficult question. I would think it would run somewhere in the neighborhood of $600.00.

DR. WILSON: If we take this contract and we divide it by the number of visits, the figure is $1,600: including our own staff personnel to organize this, the question of travel, the question of meeting with you people and making sure of the kind of things that you want, the problem of locating the person. This is quite expensive and, as you know, continuing education in the State of California is totally without funds by the State, totally without funds. Neither my salary nor Dr. Kimbrough's salary is guaranteed. In terms of fee income, that is the figure.

FROM THE FLOOR: You figure $1,600 per session?

DR. KAPLAN: That includes your costs?

DR. WILSON: Yes.

DR. KAPLAN: The costs that they would pick up would be just the costs of having the man come to their hospital, not the other costs.

DR. WILSON: Then you are back to Dr. Kimbrough's figure.

DR. KAPLAN: $600.00.

FROM THE FLOOR: These are the figures that we need. We are not interested really in getting in on a system of federal subsidization. My God, my taxes are high enough as it is. I want to do something that can cut out some of the excess federal spending, even though we need it at times. But we would be willing to contribute a share of the expense by the Medical Society, our hospital, at least on a quarterly basis within our ability to pay ourselves.

DR. WILSON: There is one thing I would like to say concerning what Dr. Kaplan brought out so very aptly, the differentiation between saving money and the point you brought out for spending money. We have a grant at the moment on our emphysema research. We have been doing routine examinations on a weekly basis on 44 persons; and on a bi-weekly or monthly basis, on a large group more, a simple pulmonary function test, including PCO_2. In 23½ months we have not hospitalized a patient. We know what the rate is in the desperate emphysematous patients in the county; we know what the cost of hospitalization is....

DR. KAPLAN: ....you said this program costs $70,000 to support but that in saving of Medicare fees it was $150,000 because of the training that these physicians got, there would be absolutely no question about getting funds. In fact, we probably would get a 15 to 20% increase, and they would tell us to go and do it other places.

FROM THE FLOOR: I think it is extremely unfortunate that we got into the question of money. As I look at it, if you show that the physicians are losing $16,000 in an area, it means the Federal Government is going to get $8,000 less in taxes, so if you go that route, we are dead.

MODERATOR DR. KIMBROUGH: If you are out of your office for 24 hours and you miss fifty patients, then you have 100 the next day.

DR. KAPLAN: The realities of it are, I think, that we all agree the program is quite good. And I think there are items that we can find that we can measure that will show some of the effects of the program. But getting back to the true realities, the money situation is extremely tight. We have five to six times more requests for dollars than we have dollars available to spend. If we can, in terms of payoff from developing our program as a new organization (which is only two years old) show the priorities are such that--they are going to have to spend the money where they are going to get the largest amount of returns for their dollars.

MODERATOR DR. KIMBROUGH: What about a situation like this? If we know that there are perhaps three times more diabetics undetected than there are detected; and if we were to spend $90.00 for a glucose tolerance test for every patient over 35 or 40 years of age, and we would detect all of these patients and treat them, then we could cut down on the morbidity eventually. How would the government look at this?

DR. KAPLAN: If you could prove that through spending of dollars you reduce mortality by a significant amount, then this would be a worthwhile thing. After all, we are interested in people. People are our prime aim and patients are people, and if we can reduce mortality, then we keep people alive and by doing this, detecting it early, we reduce the complications of diabetes and then we are far better off.

FROM THE FLOOR: I think it is important that it is not the mortality that is expensive; it is the chronic morbidity that costs in the long run. If you can prevent that--a program this short can't show very much definitive except by projection. You can project what you can do, but you can't guarantee it until you have time to pick up the things and prevent it. It is the long-range things that cost money.

DR. WILSON: Do you think this would be a good time to introduce Ruben to the group? I think he will be meeting many of you soon. I don't think his role has been established. This comes into the crux of what has been accomplished.

MODERATOR DR. KIMBROUGH: Mr. Ruben Dixon is with our staff and his role is....

DR. WILSON: Since Ruben and I have been chatting about this in some detail, obviously there are a lot of man hours involved in finding out really what has been accomplished. Ruben's particular interest in this whole question of trying to put together things in some comprehensible way is that he is going to try to find whether there are areas...where you think there has been some real value; whether it is in interest of physicians on the one hand; or practical facts of life and death and morbidity on the other...

MODERATOR DR. KIMBROUGH: You are a social psychologist, which is what you are listed as.

MR. RUBEN DIXON: I am really a mathematical psychologist. I don't know whether there is much more to say in addition to what Dr. Wilson has said. Obviously, the things you say, indicate that the subjective value of the program is unquestioned, you are all happy with it.

I am looing for the tangible things, the things that Dr. Kaplan is talking about, that I can measure; that is, reduction in any of these areas or improvements; and it may be, as in the case of doing this glucose test, that the cost might go up but the patient care would be much improved.

I think, as Dr. Kaplan pointed out, this is a real accomplishment for this sort of program; so although that is not a dollar reduction, it is a very significant sort of thing pointed to in the conference.

I will be coming to you and trying to squeeze from you every piece of information I can, every small benefit that this program may have developed in your community.

I might suggest that you also try to include an assessment by dollars of the earning capacity of the individual who is kept out of the hospital and to include that as a vocational potential in dollars and cents.

FROM THE FLOOR: Which might not have been possible had there not been a better approach to his care.

DR. KAPLAN: If we can add this to the $200,000 that Roger saved in the Medicare figures, how much additional income was earned and how much unemployment insurance or disability insurance was not paid...

DR. GOLDMAN: I think there have to be certain premises accepted. I think that the premise is logical that the target of medical education is the patient. I think we can also accept that the medical profession's regard is not dollars and cents, but for patient care. And I think that these men who have come from these outlying counties to spend a day here, particularly during the weather that we are having now, and the things they have said are almost something you can document. They are all very enthusiastic about this program, but the purpose of this is really medical care.

I think it is very difficult to document a good part of medical education, to say these doctors are better doctors now, or they will be better--it is difficult to document. But if we are going to assume that education in any form, or medical education, is directed toward patient care (and I think that is certainly acceptable) then, from what was said here today by these men...is a pretty good documentation. If you took a photograph of these men sitting around the table, that would be documentation.

To put it all in dollars and cents is very difficult, yet I am very sympathetic with Dr. Kaplan's problems.

MODERATOR DR. KIMBROUGH: He does have to deal with conservative congressmen, I am sure.

DR. BARNET: I think we are deluding ourselves to think that anything objective coming out of this program...including patient care...will make a change in patient cost.

The program, first of all, is so diffuse in terms of communities and affecting communities and individuals that I understand it is a problem; but I think you are just chasing around in the dark.

Even if you do show something happening, I really don't see where you can show that there is any possible correlation between it. You have no controls, no prior controls, you have no concurrent controls; there is just no reason to anticipate that you are going to get anything meaningful out of it. You may get some data, but I am sure it has nothing to do with what is happening here.

The thing about pulmonary function tests that happened in San Francisco, the detection of diabetes, this is not anything that you will be able to document very well.

We had talks on epilepsy. I don't know what the mortality for epilepsy is in Reno, but I am certain you are not going to be able to show any significant changes.

DR. KAPLAN: But there are ways of measuring attitudinal behavioral changes.

DR. BARNET: This is something different.

DR. KAPLAN: They can be measured in ways that can be quantitatively illustrated.

DR. BARNET: You have no controls, though.

DR. KAPLAN: This is what we are hoping to work into the next contract, some way of developing controls. This year was experimentation. This was a pure unorganized, in a sense, experiment that there were no controls; that we just went ahead to see if this did work, what the reaction would be. And it was on a level that we just had to measure people's feelings by measuring concrete particular items.

Hopefully in the future we can measure some concrete specific items that will be reliable, that will give us some data.

FROM THE FLOOR: I think in general, doctors are making a mistake putting this on the basis of money. Dr. Wilson told us about saving $160,000. If you want to put it on money alone, wouldn't the State have been better off to have the fellows die at the age of fifty, anyway? Then they wouldn't even have to pay the $40,000. This is the kind of mistake we are making, I think, including this on an economic basis; whereas if we save people from getting complications of diabetes, they may end up at the age of 95 in a nursing home with senility, and they are just as expensive for the State to take care of there as they would have been if they died at 50 or 60 with complications of diabetes. This is where we run into a raffle that we can't get out of.

DR. RICHARDS: We are talking about two things: One is continuing graduate medical education, and the second is the proper method of delivery of health services. I think we have to clearly realize that the program we are concerned with is the continued graduate education of the physician.

The other things are things in a totally different area. I think we have to make the basic assumption that Dr. Goldman made; that is, in general, the better educated the physician is, the better quality the medical care will be in his community, and that is as far as you can go. You either accept it or you don't. If you accept it, you try to continually educate the physician and it is a lifelong process. I don't think you can mix it up with methods of delivery of health services, which is a completely separate problem.

MR. TUCKER: I would like to make two points: First, you gentlemen talking from the point of a practicing physician. We, Dr. Kaplan and I, have to talk in terms of the government way, and the government way oftentimes is very distasteful because this is the way we get money. Whether you want to show it on an economic basis or not, we are trying to tell you this is the way to get money. There is no other way to do it, but show in concrete documented fashion that something was gained by spending these taxpayers' dollars.

I don't care how you fellows argue about it here. If you want us to support you, these are the kinds of facts we have to take back.

Number two, I want to take the onus of this problem off our shoulders. It is not Dr. Kaplan's problem and mine. We have plenty of other contracts. You got a good thing going here. We can't support you ad infinitum. We are going to chop off these dollars either this year, next year, or two years from now. What are you going to do then? That is all we are asking. It is as simple as that.

FROM THE FLOOR: You have contracts similar to this in other places?

MR. TUCKER: We have twenty contracts of varying kinds, not similar to this.

FROM THE FLOOR: Not physician education?

MR. TUCKER: This is the only one on Physicians-in-Residence that we have.

FROM THE FLOOR: What type of contracts are the other twenty?

MR. TUCKER: I couldn't take all the time.

FROM THE FLOOR: Give me an idea.

MR. TUCKER: Physicians' Interchange Program at Jefferson Medical Center.

FROM THE FLOOR: Which means what?

MR. TUCKER: That the physician in a hospital comes in and spends a week in the teaching center. The instructor goes out and spends a week in the hospital. They both gain from the interplay.

The Post-Graduate Medical Institute where they are taking forty hospitals and investigating and recommending a type of continuing education that will be conducted in these hospitals is another one.

At Utah we have a program on anesthesiology by preceptorship, where the physician is out in the boondocks, who do not have an anesthesiologist there, so he in turn can do it rather than the nurse doing it--these are the types of things we are doing, but this is the only Physicians-in-Residence program.

FROM THE FLOOR: And the purpose of this is to teach physicians to be better physicians.

MR. TUCKER: That is our main objective, to get better patient care.

FROM THE FLOOR: That is your interest?

MR. TUCKER: Yes, sir.

FROM THE FLOOR: Why can't you approach it that way to the Government, say, "This is what we want."

MR. TUCKER: Because in every case we approach the Government to task for money, we have to show them evidence that this money has or will in some way produce results.

FROM THE FLOOR: We have only had one year. You have time for that.

MR. TUCKER: You tell your congressman that.

FROM THE FLOOR: If the congressman is not interested in teaching us, we are whipped to start with.

MR. TUCKER: He is interested. They are spending a lot of money for new facilities and special improvement grants for medical schools and all sorts of things. They are interested--this is just one modus operandi where we are assisting in continued education; we are also helping in the regional medical programs for millions of dollars. They are interested.

I am trying to bring it to the actual facts. I see it as your problem, not ours. We want to help you as much as we can and as long as we can, but we got to be armed.

DR. KARAM: When you are narrowing it down to the problem, you are implying that the medical care could be better all over the State of California. This is one approach to try to make it better, and if we fail, to somehow find a way to continue this program and the money stops. Then if the problem still exists, there was an implied suggestion from Dr. Kaplan that there might be some other measures then that have to be imposed in order to improve the care. Or does the problem stop by losing the money? Or are there other problems that are going to meet the needs by the Federal Government?

FROM THE FLOOR: How was that threat?

DR. KAPLAN: I am not threatening. The problem is that we all admit that there are ways that the patients could get better care. I don't think anybody will argue that. All of us have at some time treated a patient and realized afterwards, or the next night we pick up a journal, that there may have been a little bit better way we could have done it.

We realize we have shortcomings and we try our best to take care of the patients, but not all physicians are working at this type of thing. The physicians that should be here are not here; but they wouldn't be here even if we sent them gold engraved invitations. There are a lot of physicians that won't come to continuing education. There are a lot of physicians who feel, "I went through medical school, I graduated, I did my internship and I know everything I need to know, and I don't want to learn anymore." We have got to get to those physicians.

We have got to find out how we can reach them and get them to realize that they need more education and that they can get it without being embarrassed; that they can get it in such a manner that it is convenient for them and in such a manner that they can use it.

Now, what we are trying to do is to reach physicians through trying various programs. The Federal Funding System is either grants or contracts. Contracts are monies that are called direct operational money--that the agency uses to go out and stimulate. We use this contract as a means of going out and saying, "We would like to try this experiment and see if this works."

On the other hand, when people come to us with an idea and they apply for money, and if they are successful, they receive a grant, and we cannot in any way control it, but with contracts we are trying to stimulate interest.

Now, we can only stimulate the interest and get it going with our contract money. We don't have sufficient contract dollars to go and continue these things on. The problem is, this is a good program; how do we continue it on? We can't keep pouring dollars in year after year. If we do, we won't have dollars for other things. If we took other contracts that have expired and continued them on--let me give you an example. Our problem in the Division of Physician Manpower is to turn out more physicians. We had a contract to retrain inactive physicians. The contract originally called for six physicians. Through good management we were able to graduate nineteen. It was an absolutely successful program, and we said that we put in this many dollars, we got out this many more practicing physicians, but we couldn't continue this. We found there were something like 271 physicians ready to go and $8,000 per physician per year, so that we would have been broke and we couldn't have done another thing. We couldn't have supported this program, so we cannot continue on with contracts in a supporting mechanism.

We have to find other sources, and this is the problem that we are in, and this is why we have hoped that we can stimulate the practicing physician to get out and figure out ways of getting support for these programs by himself.

DR. CARBONE: As I listened to your discussion here, it seems to me that you have to justify is results, and if your program is showing results, it is showing more merit. And if we start out with a premise that we are going to have a continuing education program, we can measure something irrespective of dollars and cents, and that is the number of people participating in the program who would have been reached in no other ways. For example, if these various men who have come here can document that last year in the city of X in the Valley, maybe one or two men came up to the University for graduate courses. And when we went out into the community twenty times that many men had that much instruction, which is fifty times more instruction than the previous five years. This is a result you can take to Congress, if they are interested in continuing education and the progress of medicine in the community, irrespective of dollars and cents.

This is what our goal is, and I think you can do this. Every one of the men from the various communities has an idea how many men have been to the University of California or Stanford or wherever it is for graduate training, and all they have to do is document the number of men who attended the conferences and you can do it this way.

DR. KAPLAN: There is a danger of the number of people that attended. We all know how many people come to a meeting, sign up and walk out the other door. This has become well recognized in Congress, that the number of people attending a course is not necessarily the number of people that make the results.

DR. CARBONE: Some of them sleep, too. This is reaching people.

DR. KAPLAN: This is reaching people, but in terms of patient care, can we go one step further and see if we reached twenty physicians more than we would have reached without this program? And as a result of these twenty physicians we were able to handle X number more patients, or we were able to keep that many patients out of the hospital? This goes one step further and we have got to go beyond measuring how many people attended.

DR. CARBONE: You won't get the data for some time. If you raise the practice, it is not going to be obvious until the next five years in the number of autopsies, for instance. If you raise basic medicine, that will go up over several years and the number of operations will diminish.

The first step is to document that you actually instituted an educational process that is appealing to bring these men that could not be reached in any other way.

DR. KAPLAN: One of the best ways that is appealing is by showing the physicians are interested enough not only in attending but in supporting it.

We had a problem with medical schools in which the medical schools thought that a certain group was very good and they ought to be supported. They were going out and doing an excellent job, and this is the type of thing we needed in medical schools. And so when they came to us and said, "We want you to give dollars because these are the things that are good for medicine, good for medical education and the best things going on." We said, "We don't have the dollars, but you have them in the basic improvement grants, which is your money, and the special improvement grants--those of you who got them--you can put your monies up in that." They said, "No, we can't do that. We need the money for other things."

So you see, it is a real problem that the Federal Government gets into. People will tell us it is an excellent program to continue; but when you ask them to put up the dollars themselves, they say it is often not as good as they want it to be. But one of the things to prove that it is good, is for the agency or the institute or the doctors to put up money to support it.

DR. KARAM: You gave some figures where a community might be considered to put up $15,000. How about some method like that where you figure out how much money has been lost by the physician donating his time to that thing; and that could be considered an interest on the part of the community attendance. And you can show your congressman how much the community has put up versus the Government.

DR. KAPLAN: It does not carry much weight. If $000 is not what the community can afford, fine, something, a token, an interest, it is just that. Saying that doctors put in so many hours--the Internal Revenue Service won't allow you to take this off. If you figure you contribute thirty hours a year to some charitable organization, you can subtract $900 from your income tax because you gave that amount of hours. It is the way the Federal Government looks at it. It is a matter of how many actual dollars, not the equivalent dollar time. It is a fact of the way the situation is. There is no way we can get around it.

MR. TUCKER: I would like to interject here, I am sure you want to talk about other subjects besides this, maybe we can resolve the dilemma by being a little bit more objective about it now, instead of philosophizing here.

With what we have heard today, with the proceedings of this discussion and with what Mr. Ruben Dixon is going to dig up between now and the time of the final report, I feel fairly confident that we will probably be able to support this program. Maybe not as much. We may massage Roger's budget downwards considerably in some form. This is not a promise, just my own personal reaction.

Assuming that to be true, then this problem is not going to be current right at this moment. We don't have to resolve it today. We are only postponing it for a year.

I said it is a hypothetical case. Supposing we do support you for a year. A year from now what are you going to do? Be thinking about it and be presenting this thought back and forth as the next year unfolds, because then it will become a more serious problem.

DR. KAPLAN: As we know from experience, the time to start thinking about it and doing it is now, not wait until next year to do this.

We are enthusiastic about the program, obviously, and you are enthusiastic about it. Let us say we do get it into the Review Committee and everybody approves it and says, "Fine," then it has to come up about funding levels and the total dollar amount involved that we have to lay out of our total pot of money, which is not very much, will make a big difference in the amount that gets funded. And whether you get an approved and not funded contract or an approved and funded contract--and those are the realities.

DR. MAC CARTHY: I understand what you are saying, Dr. Wilson and Dr. Kimbrough, of sending out lecturers to us that may be specialists in rehabilitation, because if you want figures on what you have accomplished, then maybe the whole program should be distorted to one minor aspect, and I think you should present that fact in terms of how easy it would be to distort this.

DR. KAPLAN: This is true, but if you establish what your needs are in your community hospital--and I think Ruben can help you in doing this--in establishing the needs in such a way that they can be measurable, you can take almost any need and reduce it to measurable terms.

MR. RUBEN DIXON: We hope so.

DR. KAPLAN: And reduce it to measurable terms by stating it. Then you can measure it. You wouldn't have to be concerned by picking a subject just because it is something we can measure; you can measure almost any subject, which you can pick, if you do it right. So I wouldn't subscribe to skewing the problem just for the sake of measurements.

DR. REIDER: If you have the basic knowledge that the program is desirable, why can't you look at it also another way? Simply thinking out loud now, suggesting that X number of dollars are given for a course in their own home base, and if those doctors were to individually or collectively make the trip to San Francisco, then what would that cost? In other words, you are delivering a service which is a desirable service for much more economic cost, I would think, than would be possible under the only other alternative toward them getting it, flipping it around the other way.

DR. KAPLAN: If you have ten doctors that you want to send to a course at Roger's office?

DR. REIDER: Yes.

DR. KAPLAN: And you figure out the cost of plane or car travel, plus the per diem expenses for each one of those men, multiply it by ten and compare it to the cost of Roger sending one man to you for three days.

DR. REIDER: That is what I am saying.

DR. KAPLAN: Then you got how much would the personnel cost you to do it. Let's say this program did not exist and you decided that you and ten other physicians want to come up to San Francisco to take a course in X disease. How much would it cost you personally, and then figure out what it would cost Roger to send one man to you, that is all.

DR. REIDER: Yes.

DR. KAPLAN: Are we talking on the same line?

DR. REIDER: The saving being to you personally. That would be tremendously cheaper, I would think.

The only other alternative is not to have the continuing education along these lines, in which case you would save all of it, but in line--

DR. KAPLAN: You wouldn't gain a thing.

DR. REIDER: But if you are looking for ways of measuring, there are all these different ways of viewing the problem. But I think you have to go into the total evaluation of the program by committing yourself to the question, "Is it desirable or not to have the program?" Then find out what is the most economic way of delivering the program to completion, and calculating your savings on that basis.

This is a suggestion. I am only suggesting to you an alternative way.

DR. KAPLAN: If we had unlimited funds, there would be no problem; but we are stuck with a limitation of our funds and an over-subscription of the people who want the funds, and we are trying to find a way to get this thing funded; that is what we want.

My idea, when we were asked to participate in this program, was for the specific purpose of trying to educate physicians.

FROM THE FLOOR: In communities where there aren't academic facilities handy and for the purpose of reaching individuals who have not participated in postgraduate courses over a long period of time--I thought that the purpose of the program was mainly to try to get all physicians in areas who have not continued their medical education to be benefited by sending out the faculty members from the University. Now, all of a sudden, we are threatened with cutting this thing off before we even get started, and if I understand right, I don't think that was the purpose to begin with. I think if I went back to my medical society and said, "Well, now, we are more or less assured we will have this program for another year, but next year it will cost you about $800 every three months to have a man come up and speak to you," I don't think anyone in this group who would take it back to the medical society would buy it.

MR. TUCKER: That is the answer we need to take back with us.

DR. KAPLAN: Eight hundred dollars for a three months' period.

FROM THE FLOOR: You mentioned the figure for a speaker. It took our society ten years to get the doctors to pay a salary for an Executive Secretary. We finally got an Executive Secretary who would go around and lobby and keep us informed what the Legislature was doing and what is going on in Blue Cross and C.P.S.

If I went back and told the group of doctors in our society, "Well, we will have this program for one more year, but they expect us to pay for it after that, in order to get the same type of education to pay $500.00 every three months for a speaker," then I am sure--

MR. TUCKER: You were not told when you were going to ask to participate in this that it would be an ad infinitum program, were you?

FROM THE FLOOR: No, I don't think we were. We were not told either that we should more or less try to use this program to stimulate our group in the community to support their own program.

MR. TUCKER: We are not advocating this. We are saying if it is as good as people indicated, you would want to continue it, because you have already admitted--most people have--that it was a unique way to get more people to attend continuing education experiences than you ever had before. It was good and the University is willing to support this kind of endeavor, and they don't have the funds and we can't support you ad infinitum.

At that point somebody has to make a decision, because the program costs money, and if it continues--

FROM THE FLOOR: Why did we start if you did not have the money?

MR. TUCKER: We had the money for one year.

DR. KAPLAN: Who should be responsible for the continuing education of the physician?

DR. EVANS: In Tulare County we have discussed this somewhat and the figure we talked is about $500.00, which we are willing to pony up per visit this year. I have no firm commitment of that, but that is what we have talked about.

It seems to me that the value of continuing education is to the physician. He is the main one who is going to benefit from it and, if necessary, we are willing to pay for it. This would be my own personal feeling about it. Personally, I would be willing to go that way.

DR. BIFULCO: My impression is pretty much the same as Dr. Evans', with other members of the medical society. This figure of the cost in the hospitals themselves, they indicated this, three of them, and I am sure that the hospital administrators are not talking about spending money, but they suggest that they are interested in participating in this program and they will have some money available. I don't think that the whole program could be funded from our funds next year, but I am sure a sizeable portion of it could be.

I think that the physicians in our counties were so impressed with the fact that we do have people come into the community where they were on the spot with their patients at that time with this personal contact, that this does a great deal more than coming to the University Medical Center for a similar type of program.

DR. KAPLAN: That is the type of response we need, that the physician himself is willing to put in the money to do it, because he feels the program is good, it is the best thing he can do for his money.

DR. BIFULCO: He has to put his money into his own education sooner or later. Up to this point he had no choice. It has been an embryonic program and I am sure the physicians in our county are willing to continue it on this basis.

DR. LYONS: Having had the pleasure of living in Paradise for three days, I can see this particular community is wealthy beyond the average and could probably well afford this; but there are some communities that could not. And before you go any further in the whole thing, maybe you should send out some sort of a questionnaire to various participating groups and see whether they would be willing to underwrite five percent or any token amount which then you can go and say, "Five percent this year, ten percent next year," and if it is not good, drop it. And if they won't put their money where their mouth is, it wouldn't do any good.

MODERATOR DR. KIMBROUGH: We have not heard from Dr. Sheppard yet from the Pacific Medical Center.

DR. SHEPPARD: I think in my institution, since we are not participants in this, that gives us kind of an interesting perspective.

As I have listened to the discussion here, I think I have been impressed by the fact that there has been a very enthusiastic description of a method in search for a problem, and the problem may be properly identified: the descriptions we are hearing of a favorable reception of an entrance of the University into a rural and remote community, and I think this is very healthy.

I do not think I have been hearing discussion really addressed very precisely to problems of continuing education yet, but I think in the year to come, that you will build on the bridge-head that you have made, and I certainly think it would be premature to curtail this project at this point. I think you really are at the point of breakthrough.

DR. WILSON: I would like to ask a question because we have now in most cases completed our cycle. One of the things I think we have to face is that we are trying to show this is a method. I quite agree, this is really the function to demonstrate, and we felt that one of the ways which would be most helpful and most solid as a demonstration project, but not as necessarily the kind of thing that would be done in other places, which was to use the same people again so that they could go back with some familiarity with the people, the institution, the problems the institution was dealing with, et cetera, in an attempt to show that this was a worthwhile thing in education.

I realize the tremendous variety of things that we all want comes up immediately. Lord knows I think you all feel this, the variety of people. In a sense, you are participating in--I hate to use this word--an experiment, and this is true.

Would you be willing, do you think that this return of the same people would be acceptable to your own groups? This is an important part of our own planning. Might I ask that question?

DR. BIFULCO: To have repetitiously the same people all the time?

DR. WILSON: Just twice.

DR. BIFULCO: I would say no, personally, although I am in a County Hospital. I am sure the County Hospital will support this, whether in totality, but I am sure that we have the responsibility of keeping our physicians on a continuing education basis; if the Government supported half, I think our County would support half.

The other thing that is most important, as far as I am concerned, as far as the hospital is concerned, is the bond with the University. This is, I think, the great stimulus that has come in this program.

MODERATOR DR. KIMBROUGH: We have not heard from Miss Mazelis.

MISS SARAH MAZELIS: I am bleeding the same as you are. We have so many good things starting and we would like to try to continue them.

I think this next year is going to be the payoff on what is going to happen. I don't think we need to feel the least bit upset that we did an experimental program, because we did not even know when you started this program whether such a method would work. There were some real reservations on the part of many people that you could not send people from a University into a local community and have it work, so the fact that we know this is a method really points ahead.

It seems to me there is another level we have to work at: Number One, can we measure it? And secondly, how do we fund it? I would have been very disappointed if such an experiment had not occurred, which is that we would have used a method we knew was not working, which is bring people in. Now we have one more method that we did not have before.

Also, I think we will have a reflection on the other method. The fact that so many of your medical staff went out into the community to do this teaching should certainly reflect itself in the kind of courses we give in continuing education in San Francisco, because they are much more aware of the kinds of question and practice in the community, and I think this kind of reflection is a payoff for us.

I would think that this one year a lot has happened and that we should be real pleased that some of these things happened. We just have some more problems to face, and money is one of them and measurement of how successful we are is another, and with Mr. Dixon I think the idea of measurement should be not that impossible to do, so that we could have some data which would be helpful to us.

I like the idea of going ahead.

MR. TUCKER: I would like to get back to Roger's question, because in our discussions a year or so ago when we brought this thing into focus, one of the things that we thought would be of value in evaluating the program would be to have the same Physicians-in-Residence go back a year later and he then, in talking to the people that he became acquainted with, could in some way get a feel as to whether he had made an impact or not.

This in itself would be a measurement of success or failure in each individual hospital.

Would there be an objection to that person coming back, not to do the same thing he did before but to come back and visit for a day and answer the questions that maybe have developed in the meantime?

DR. BIFULCO: When I said, "No," the reason for it is that I wanted a wider variety. The men that have come in were fine and stimulated us, but, by the same token, we want a wider variety,

MR. TUCKER: But you are not opposed to having them come back a year later and holding one little visitation on the same subject?

DR. BIFULCO: No.

MR. TUCKER: Does that answer your question?

DR. WILSON: I think so. I think this is important in our design.

MR. TUCKER: Does anybody else have anything to add to that particular point, because it is an important point for a second year.

DR. REIDER: Why can't the Administrator or the Medical Director make this assessment?

MR. TUCKER: He can, if he is willing to do it.

DR. REIDER: He is possibly in a better position to measure the impact of these things over a longer course of time.

MISS MAZELIS: Could the men indicate some of the things that they thought would have happened as a result of their being there, the Physicians-in-Residence? Could they list some of the things that they thought would have happened or should have happened as a result of their being there, and then somebody else could take a look.

DR. WILSON: This would be possible and we thought of that, particularly in the broader fields which, on the whole, we have gone into.

Most of the people we have sent out are not ultra specialists. We have not sent out any opthalmologists, but in the debriefing, which is one of the most important things, we have asked and received--except for the reason that Leon here mentioned--a very considerable amount of concrete evaluation of problems.

Dr. Griffeath, the stuff on the early intensive coronary care unit was immensely valuable. That has been communicated back to them. Jim Ward and I spent an infinity of time discussing nurses doing routinely vital capacity to post-operative patients. The question of pulmonary testing, how this is to be developed in the community, which is just under way with this now, and the question of a small modification in one of the rooms in this hospital which we discussed with the Board of Trustees.

Each one of these chaps has done this. Ray, for instance, came back with a great deal of data from Salinas and this is part of the feedback that we are going to be able to provide the hospitals concerned as it becomes possible to collect.

We have not been able to handle it as we would like, simply because we don't have the money for sufficient staff and visits. The generosity has been considerable, there is no question about it, but there was a limit about what they could give us, so our personnel has been limited, but you are darned tootin' there is feedback, lots and lots of it. There will be much more, particularly with Ruben involved.

If you like, some problem solving existed wherever Physicians-in-Residence went out, and there was a real intent in problem solving in cooperation with the community, not telling them.

MODERATOR DR. KIMBROUGH: We have about six minutes remaining.

DR. FRANK H. LEEDS: So much of this evaluation is very subjective, and if you can evaluate your own work. Some of us know our communities so well. I think I have been back to Ukiah at least once a year for the past eight years, invited through the University or through the local Medical Society.

They were having a problem with ruptured aneurysm in a community too far from San Francisco to send us a ruptured aneurysm. The only way to learn was for the Board surgeons or trained surgeons to do elective aneurysm. One of them came down and worked with me and I went up there twice and worked with them, and they are doing their ruptured aneurysm now and their mortality the last time was better than mine, so I said, "you have not done enough, you need to do a few more."

The other thing is, in the group with which I was there three days, there were thirty men on the whole. If you say it costs $600, this would be $20 for the three days, that is $7 a day per physician. You can't get a good theater ticket in San Francisco for $7. It seems to me that would be very little.

MODERATOR DR. KIMBROUGH: On the other hand, there are many hospitals which we found throughout our television program where there are only four or five people on the staff, and I think it is unfair to ask them to come up with this amount. In this instance it was a thousand dollars for the television.

DR. LEEDS: Could you use the extra government money that might be available? I heard one of the groups has seventy men. They certainly could afford with a small contribution each to pay that, and for those groups that can't, whatever small Federal funds might be available to be used.

MODERATOR DR. KIMBROUGH: I would hope that you would be receptive to such an idea.

DR. KAPLAN: Yes.

DR. WILSON: There are several things we might take into account. The question has come up, for example of X dollars extra for continuing education. Oregon has done this, there is a question of $10 extra on the dues to be applied to the continuing education project .

Realizing how large an association we are with 20,000 members, it is going to take a long time to get this through, particularly with La Mesa being so conservative; but the fact remains we can see glimmers that either less well off areas or on the other hand small hospitals become involved, and one of the reasons we used small hospitals here or relatively small hospitals was to show that there was indeed a tremendous response.

DR. KAPLAN: In fact this very thing that you're saying now that everybody in the California Medical Society does have to contribute $10.00.

DR. WILSON: They may have.

DR. KAPLAN: The very thing we want to know is what is the best methodology to do this, and this is the reason we're doing this contract and part of the reason we have the Yale study with the Fellows-in-Residence, with the Post-Graduate Medical Institute, to find out is this the method to do it when it comes time for the physician to be putting his dollars in, and what is the best method available for him where he can derive the greatest benefit for the least cost?

This is what we're striving for.

DR. WILSON: Also what are the methods, put them in the plural, because there are many ways of skinning a cat.

DR. KAPLAN: There is the old saying that for every 100 physicians you have 101 opinions.

DR. EVANS: As a member of the Medical Society, the men in our society would support it, I would say, and they would cough out a great deal more out of their own pockets than if you tacked $10 on for a personal bill that comes from the CMA. That may work eventually but to put the program on its feet by the physicians, they will do it through their own pocket.

FROM THE FLOOR: Another important aspect has to do with something I said earlier, Dr. Kaplan, it is a responsibility of us to find methods to provide for continuing education for ourselves, and that if we don't do this and we have heard this about other aspects of practice, if we don't do this in the Federal government and other governments then eventually they will do it for us. So this is one of the methods and a comparatively inexpensive one in which we can provide for continuing education.

If you're not able to sell this to the government and eventually they don't buy it, they will then be exposed to the other alternative, and that is to do it themselves, and can they do it at a cost less than this?

DR. KAPLAN: The problem is that we sell it as an idea but the amount of dollars we have available today to do this with is limited. If we had unlimited dollars it would be no problem, but we have limited dollars and we are in a very tight situation.

DR. MAC CARTHY: No one put any emphasis on the competitive aspects we have in the County Medical Society on dollars. We provide a speaker at least six meetings a year with at least a $100 honorarium. These men gave good, sound, basic medical lectures.

I think we have to recognize it might possibly be more valuable than a three-day physician-in-residence. This is something that has not been mentioned that should be.

We also have a Cancer Seminar Program coming up which has been funded by the American Cancer Society and Merck, Sharp, Dohme Foundation, which again is a resource that we have been able to find outside of the Federal Government.

I am troubled by the opthalmologists in our community, will they want to contribute to a discussion of orthopedic surgery? Will they want to contribute $600 toward getting an orthopedist? The answer, I think, is "no," they would rather go to an opthalmology meeting, and if they are given their choice of spending $50 a year, they would say, "we would feel that our patients would benefit by driving up to UC and going there for a few days," so when we get into a community where you are talking about a large number of divergent specialities, the situation becomes a little bit more complex than has been implied here in terms of asking individual doctors to fund an education program.

DR. KAPLAN: The only rejoinder is that the patient has more than eyes.

DR. MAC CARTHY: Not to the opthalmologist.

DR. KAPLAN: But we should be more than just eyes.

DR. WILSON: Among other things, when Ruben comes to your area he has some ideas or he will have some things which he discussed with us all together, which we would hope will be of interest in your discussion with your people; because we are very conscious of this, too, and opthalmologists I say specifically, because the opthalmologist does best by going out, because of the equipment and demonstration which is not possible.

MODERATOR DR. KIMBROUGH: I want to thank you all very much.

(Whereupon the meeting adjourned at 5:10 p.m.)

ED053285

PHYSICIANS-IN-RESIDENCE

#PH 108-68-12

SUPPLEMENTAL REPORT

VT011201

TABLE OF CONTENTS

INTRODUCTION

ADDENDA

- A LIST OF PHYSICIANS-IN-RESIDENCE
- B PHYSICIANS-IN-RESIDENCE INTERVIEWS
- C TULARE COUNTY MEDICAL SOCIETY
- D SYNOPSIS OF PHYSICIANS BY GEOGRAPHICAL AREA

U.S. DEPARTMENT OF HEALTH, EDUCATION
& WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

INTRODUCTION

This document is the concluding section of the final report on the Physicians-In-Residence program (Contract PH 108-68-12), previously submitted on March 3, 1969.

The principal additions contained here are the confidential reports of seven P-I-R physicians who had not yet visited their assigned communities at the time of the prior report. Also included is a rather detailed statement on a return visit to hospitals in Tulare County.

This document also contains detailed information on physicians in the communities involved in the program. This data is submitted to indicate the nature of the medical communities that have participated in, and been served by, the Physicians-In-Residence program. For the record, it should be noted that the P-I-R program served not only the 14 officially participating hospitals, but nine others as well: Oroville Community Hospital, Glenn General Hospital (Willows), Mercy Hospital (Merced), Memorial Hospital and Doctors' Hospital (Modesto), Modesto City Hospital, Dameron Hospital (Stockton), Community Hospital (Ft. Bragg), and Memorial Hospital (Lindsay).

The main conclusions stated in the previous report have been sustained, viz., (1) the P-I-R program has clearly filled a medical need, and, (2) it has been accepted by physicians as a useful educational device. More specifically, activities during the period since the last report show that, (1) participation has continued to rise and remains high, (2) clinically oriented sessions were well organized and personal contact with local physicians was maximal, (3) there is clear evidence that life-saving and therapeutic procedures have been adopted as a result of the P-I-R program, (4) improved clinical management in one hospital influences procedures at others near by, (5) there has been a manifest increase in concern and interest in continuing education as such, (6) various steps have been taken to improve and modify local health care facilities.

In summary, the personal commitment of participating physicians seems to have been thoroughly justified, both clinically and educationally. For these physicians and their patients, the Office of Continuing Education again expresses its appreciation for the opportunity it had to assist in achieving these desirable ends.

ADDENDUM A

PHYSICIANS-IN-RESIDENCE

A total of forty physicians made visits to the following areas:

HOSPITAL	PHYSICIANS	DATE
Enloe Memorial, Chico	Harold I. Griffeath, M.D.	October 29-31, 1968
	John H. Karam, M.D.	January 21-23, 1969
	Alexander Anylan, M.D.	April 8-10, 1969
General Hospital, Eureka[1]		
Memorial Hospital, Exeter	Harold M. Lyons, M.D.	May 13-15, 1968
	Roger H. L. Wilson, M.D.	September 16-18, 1968
	William F. Blaisdell, M.D.	December 9-11, 1968
	Vincent DiRaimondo, M.D.	April 23-25, 1969
	Roger H. L. Wilson, M.D.	May 13-15, 1969
Yuba General, Marysville	Kay H. Blacker, M.D.	May 21-23, 1968
	Hibbard E. Williams, M.D.	October 23-25, 1968
	Leon Goldman, M.D.	January 23-25, 1969
Merced General, Merced[2]	Alan J. Coleman, M.D.	October 23-25, 1968
	Edward Strisower, M.D.	March 26-28, 1969
Scenic General, Modesto	Vincent C. DiRaimondo, M.D.	May 13-15, 1968
	Kay H. Blacker, M.D.	December 10-12, 1968
	Morley M. Singer, M.D.	January 7-9, 1969
Memorial Hospital, Redding	Jan Alban, M.D.	May 22-24, 1968
	Richard G. Devereaux, M.D.	September 25-27, 1968
	Stuart C. Cullen, M.D.	January 14, 1969
	Joseph Lee, M.D.	January 15-16, 1969
Washoe Medical Center, Reno	Douglas L. Crowther, M.D.	June 12-14, 1968
	William R. Murray, M.D.	September 25-27, 1968
	Gary Kardos, M.D.	January 8-10, 1969
General Hospital, Salinas	Mar W. McGregor, M.D	May 22-24, 1968
	Raphael B. Reider, M.D.	September 26-28, 1968
	M. Michael Thaler, M.D.	February 26-28, 1969
County General, San Luis Obispo[2]	Kenneth L. Melmon, M.D.	December 5-7, 1968
	Robert C. Lim, M.D.	March 20-22, 1969

St. Joseph's, Stockton	Charles T. Carman, M.D.	May 16, 1968
	Lloyd H. Smith, Jr., M.D.	May 17-18, 1968
	Victor Richards, M.D.	September 19-21, 1968
	Peter H. Forsham, M.D.	December 18-20, 1968
County General, Tulare	Gennaro M. Tisi, M.D.	May 20-22, 1968
	Edwin J. Wylie, M.D.	September 3-5, 1968
	John V. Carbone, M.D.	January 13-15, 1969
Mendocino County, Ukiah[3]	John R. Gamble, M.D.	May 22-24, 1968
	Frank H. Leeds, M.D.	October 2-4, 1968
Watsonville Community, Watsonville	Richard Leonards, M.D.	December 12-13, 1968
	Moses Grossman, M.D.	December 14, 1968
	Martin Brotman, M.D.	March 25-27, 1969
	Barry Ramer, M.D.	May 15-17, 1969

[1] Although a great deal of contact has been made, it is notable that Eureka, which was one of the orginal target areas, has made no firm decision to participate over the year. This is of great interest, because of the relative isolation of this community. Contacts were made both at the hospital and medical society levels. The sole comment that appeared contra to the proposal was, "The doctors are too busy." This parallels other experiences in a medium-sized isolated area where, for example, the CMA circuit program has been a notable failure.

Because of the interest expressed by the neighboring area at the north end of the Sacramento Valley, the program coordinator has visited Yreka about their possible participation in any future program. The funds that would have gone to the program at Eureka have been used in expansion and evaluation of the program at Tulare County, where particular enthusiasm and wholehearted support has been expressed by the Tulare County Medical Society.

[2] Because of scheduling problems at Merced and San Luis Obispo, there were

only two visits made at each community.

[3] Because of administrative problems and transition of a new local medical society president, only two visits were made to Ukiah during the period of performance.

Report on PHYSICIANS-IN-RESIDENCE Program

N. T. Enloe Memorial Hospital
April 8-10, 1969
J. Alexander Anylan, M.D.

CONFIDENTIAL

Weaknesses and Strengths of Practice: They are weak in specialty type practices, because there are certain cases that are being done by general surgeons who have rather limited knowledge and training in cancer of chest and also vascular. Some of the better internists are sending their more complicated cases out-of-town, either to Sacramento or to San Francisco.

Referral: They are referring a fair number of the more complicated cases out. They've been referring all the neuro-surgery out, but they're expecting a fairly well-trained neurosurgeon next month in town. They're all looking forward to that.

Areas of Potential Improvement: The County hospitals in Oroville are having a great amount of bickering with the politicians in the area. I was invited to sit in on a staff conference of staff committee. Apparently there's quite a move by the politicians to cancel out and close the County hospital completely as not being needed. They're having difficulty getting it manned, they have no house staff. They pay the local doctors for coming in at the rate of $25.00 an hour for manning the clinics. They then get the MediCal fee themselves operating on the patient at the County hospital.

Improvement of the Medical care in the hospital; clinically and administratively: For the area, it's a pretty good hospital. It's nice and clean and they're doing good angiograms. There's two firms of X-ray people; I forget which firm they were not too happy with, because they haven't been able to get decent arteriorgrams. The other firm has done an adequate job, and I saw some arteriorgrams which weren't bad at all. I saw a patient in consultation, and the phlebogram that I prescribed was well done on the upper arm. Some patient had a complication of a thrombosis of the brachial vein; the arm vein. They showed the block and it was quite adequate. Unfortunately, the doctors who filter in to listen to the consultant, are the doctors who least need it. In other words, they were the better-class doctors who are interested and who made it a point of coming and hearing. The people you are trying to reach were out on the golf course, it being a Wednesday. Thursday being a busy day for them in the afternoon; they weren't about to close-up-shop. I think this concept of day-time conferences for doctor's is going to be a little difficult. Many of the nurses volunteered to meet. Some of them had night duty, but instead of going to sleep they would come to listen to me. I was rather delighted with the response of the nurses. They were not young particularly, they were practicing responsible older women. We had sit-down grand rounds at Butte County hospital in Oroville. [illegible]loe was straight didactic. The doctors just weren't interested, an[illegible]ouldn't have been reached anyway. They don't like any university particularly. They're not particularly enthusiastic about Davis going in either. I don't know what they thought; I made it a big point of course of not talking down to anybody. They never even came to hear it. I just think that that area, they're a group of very smart self-satisfied, third-rate people. There's a private hospital in the area with 70 beds. It's owned by a group of doctors. Apparently it's got a fairly high level of medical practice, as good as Enloe.

Recommendations as to the methods by which the Medical Center can best meet the educational needs of the community and the physicians:

The doctors aren't interested. You can have the cause and cure of cancer, and they wouldn't cross the street to hear you. There was a guy who was interested in medical chest diseases, and he's accepted a two-month location with the university on medical chest, and physiology as a refresher. He's closing up shop for two months to come down. They've got a fine pathologist there, who used to be at the University. He's in private practice of pathology there. By and large what I saw wasn't too frightfully impressive, medical or surgically. There were about 12 to 20 doctors in attendance at each session, and about 55 nurses.

REPORT ON PHYSICIANS-IN-RESIDENCE PROGRAM

Kay Blacker, M.D.
Yuba General Hospital, Marysville
May 21-23, 1968

CONFIDENTIAL

As far as the level of practice in this small community county hospital, I didn't have much of an opportunity to judge. The program was poorly organized and the present doctor in charge of the PIR program does not have a good rapport with the medical community and is in a chaotic state himself; consequently, most of the session involved outside interest groups and lay people in the community and not physicians. (A copy of a press clipping and program format is attached to this report.)

I offered to do ward rounds, but there weren't that many patients. I did see one young man that was in isolation, but had no opportunity to observe any of the ancillary services or the general practice of any of the other doctors.

It is my feeling that they are in the process of phasing out the Yuba General Hospital, as most of the physicians in the area use one of the other hospitals there. I would certainly be willing to go back up again next year, if the program was better organized and I am able to reach more of the medical community. I do feel that the visit wasn't in vain, however, as there was a lot of outside interest and they could certainly use any help up there.

YUBA GENERAL HOSPITAL

Yuba General Hospital presents the first of a series of lectures designed to bring the teaching hospital into the outlying areas of the State.

As part of the University of California continuing education program, the first series will be at 10:00 A.M., Tuesday, Wednesday, and Thursday (May 21-22-23) and the subject matter will be as follows:

Tuesday, May 21, 1968

The Hospital - Psychiatry - The Team approach to patient care.

Wednesday, May 22, 1968

Community Psychiatry - The most good for the most people.

Thursday, May 23, 1968

Drug Abuse - Pot, Acid, and Speed - a socio-medical problem.

We regret the short notice for this series of lectures, but can assure you all three lectures will be of great interest to the medical and allied professions. It is open to the general public.

Dr. Blacker, of the University Hospital Staff, will be the guest speaker.

The Time .... 10:00 A.M.

The Place .... Yuba General Hospital
14th & "J" Streets
Marysville, California

The Dates .... Tuesday, May 21, 1968
Wednesday, May 22, 1968
Thursday, May 23, 1968

Please let us know if you are coming by calling Vicki Miller, 743-4664, Ext. 51.

L.A. Service M.D.
L. A. Service, M.D.
Medical Director

98

4— Marysville-Yuba City, Calif.
Friday, May 24, 1968

Report On LSD Users Given In Yuba Talk

By RAY SORUM

"Would we have legalized tobacco 150 years ago if we knew then what we know now?"

The comment was made yesterday afternoon during a question and answer session following presentation of a clinical research paper on "acid heads" — LSD users — by Dr. K. H. Blacker, staff member of the University of California Hospital in San Francisco.

Although Dr. Blacker's paper was confined to a group of LSD users tested and interviewed last summer and again in a follow - up session in January, the question session following his report covered a wider scope ofdr ug "addiction."

The remark concerning tocco was kind of an aside in answering a woman in the audience who wanted to know what he thought about the present legal status of the use of marijuana.

Dr. Blacker said he thought "the offense" ought to be at least on a par with conviction of the use of LSD — a misdemeanor. Conviction of use or possession of marijuana is presently a felony.

Clinical Studies

Net result of his clinical studies of 21 young persons, 15 to 27 years of age, were generally inconclusive, Dr. Beacker said, except that consistant users of LSD showed a higher amplitude, or height, of brain waves when tested by an electroenciphalograph.

(A brain during concentration, such as when working a mathematical problem, shows a minimum of amplitude while a mind "at ease" shows much higher "waves" on the EEG.)

Although Dr. Blacker's formal talk was confined to LSD, Dr. Lincoln Service, medical director of Yuba County Hospital, categorized drugs and the general type of person who indulges in their use.

Drug - Oriented

As a prelude to the discussion, attended by about 65 persons, said that we live in a drug - oriented society: sleeping pills, tranquilizers, diet pills etc.

"All of your know someone who uses drugs to some extent even if it's only alcohol or tobacco," he said.

He indicated that members of the youthful sub-culture — the young but chronologically mature men and women in their early 20's — were looking for acceptability and termed at least some of the drugs in common use as recreational drugs — meaning marijuana, mainly, and LSD.

Following Dr. Blacker's reading of his detailed and technical paper, and a question and answer session, Dr. Service closed the informal session with several philosophical remarks concerning youth and its attempts to associate with "mature" society.

Reject Hypocrisy

"Kids reject hypocrisy of adults and the 'do - as-I-do' business" when they see their parents and other "adults" condone and engage in the very things they say they shouldn't do, he declared.

Another vital point, Dr. Service said, "is that we don't listen (to young people)."

"They want to talk —they have their ideals: they want to express them and have someone listen.

"They are looking for something now right now —not looking to their future needs."

Dr. Service's concluding remarks were apparently prompted by Dr. Blaker's suggestions that the use of drugs merely expanded the general frame of mind of the user at the time he took the "pills".

The group tested were men and women in San Francisco's Haight - Ashbury District, a group of mixed national origins and religions. The main thing they had in common was that they were from middle or upper middle class families, but "put out" with the society they found themselves in.

What It Does

Dr. Blacker said, after presenting his paper, that the so-far impossible task of knowing a pre - drug personality in relationship to its later acid personality prevented a really conclusive summation of just what acid does — if anything — on a permanent basis.

As differentiated from users of other drugs ranging from booze and nicotine to heroin, LSD users are mainly concerned with a search for experimental expression and look down on "speed freaks" and "body acid" users

LSD'ers also brook no competition and will not tolerate any kind of "pecking order" in their society, Dr. Blacker said.

Dr. Blacker said the test group averaged 20 years in age and all had used marijuana before going on acid. All were passive personalities, well groomed and from "successful" families.

The "greatest danger in any drug abuse," Dr. Service said, "is that a pattern of use becomes compulsive."

Lectures At Yuba Hospital

A three-day series of lectures on mental health and drug abuse will be conducted at Yuba General Hospital beginning tomorrow at 1 p.m., according to hospital medical director Lincoln A. Service, M.D.

Tomorrow's subject will be "The Hospital — Psychiatry—The Team Approach to Patient Care."

Wednesday at 1 p.m. the lecture will be "Community Psychiatry—The Most Good For The Most People."

"Drug Abuse—Pot, Acid and Speed — A Socio - Medical Problem," will be the final talk on Thursday, also beginning at 1 p.m.

The series is open without charge to physicians, medical personnel and interested citizens, Dr. Service said. Persons planning to attend should call Vicki Miller at the hospital.

The program is under the auspicies of the University of California Hospital in San Francisco and Dr. Blacker of the staff will be the speaker. Dr. Service said he hopes this to be the first of several series to bring "the teaching hospital" to outlying areas of the state.

Marysville-Yuba City, Calif.
Monday, May 20, 1968

DWIGHT L. WILBUR, M. D.
ROBERT L. SMITH, JR., M. D.
WILLIAM F. LUTTGENS, M. D.
JOHN R. GAMBLE, M. D.
MARTIN BROTMAN, M. D.
655 SUTTER STREET
SAN FRANCISCO 94102

31 March 1969

Leo S. Kimbrough, M.D.
Continuing Education
University of California
San Francisco, California 94122

Re: Watsonville Visiting
Physicians Program

Dear Dr. Kimbrough:

As you are aware I visited Watsonville, California as a visiting physician from March 27 through 29, 1969. The following summarizes my impressions.

The following slide lectures were given as part of this program:

1. Approach to the jaundiced patient.
2. Management of hepatic failure.
3. Clinical measurement of gastric acidity.
4. Gastrointestinal hemorrhage.
5. Current concepts of fat digestion and absorption, clinical ~~applical~~ application.
6. Differential diagnosis of Crohn's disease and ulcerative colitis; management of inflammatory bowel disease.
7. Cutaneous manifestations of gastrointestinal disease.
8. Diagnostic techniques in gastroenterology (liver biopsy, jejunal biopsy, peritoneoscopy, gastroesophagoscopy).

Reception and Interest The average audience was 10 to 20 physicians. They seemed generally pleased with the program and thought it an excellent method for continuing education. Dr. Bushman, the Chairman of the Continuing Education Committee, at Watsonville Community Hospital, had requested that members of the staff provide case examples, which they failed to do. One of the reasons for this was that they probably did not have enough notice of the specific subjects.

Standards of Care and Needs for Continuing Education

Generally the standard of care in the hospital is good. I had the opportunity to review many records related to the topics which I discussed; the records themselves were excellent and the standards of care were quite satisfactory. Some of their more significant problems appeared to be in the fields of fluid and electrolyte balance, the management of cardiac arrhythmias, and the indications for exploration of the abdomen for the diagnosis of acute abdominal disease. I noted particularly that there was some over enthusiasm in some cases to explore the abdomen for diagnosis in acute abdominal disease without prior medical treatment and evaluation.

Self Assessment There was no method for evaluation of the individual physicians within the hospital. They appeared quite interested in my suggestion that the Medical Records Committee also serve as a Committee for Quality Assessment.

Recommendations for the Future The physicians in the community expressed some interest in my returning some time in about six months to review case examples related to the topics I discussed to see if there was an improvement in the standardsof care as a result of my visit. I would also suggest that future visiting physicians prepare a list of topics well in advance to provide the members of the staff with ample opportunity to pull related case records.

I found the visit an intersting and educational one and think the program is very valuable. I appreciate the opportunity that I had to participate in this program.

Sincerely yours,

Martin Brotman, M.D.

MB/rcg
enc.

Report on PHYSICIANS-IN-RESIDENCE Program
Tulare County Medical Society
Dr. Vincent C. DiRaimondo
April 23-25, 1969

CONFIDENTIAL

Virginia Finley: What about the level of practice in the community hospital?

Dr. DiRaimondo: Well, actually, I am not in a position to judge because .... I saw the community hospitals and I saw the facilities but I was unable to pass judgment in terms of the practice, [that is] although I talked in the hospitals, I didn't see patients on the wards [But] if one were to include, you know they had presented patients to me (some were hospitalized) some were not; these particular patients that they presented to me were well handled and well worked up, but this is not a reflection of practice in the hospital.

Virginia: Well, this is true. There wasn't any way you could judge the weakness or the strength in one hospital because you weren't in any given one that long, were you?

Dr. DiRaimondo: The hospital at Exeter, I just saw the facilities but I did not see how they care for patients. I was impressed with Exeter facilities in terms of a most expensive and complete X-Ray department. It was very outstanding. In the Tulare hospital I was impressed with the modern, up-to-date coronary care unit except that there were no cardiologists available. And they were in the process of rebuilding the intensive care unit. In terms of the hospital in Visalia, the Visalia people were moving into a new hospital from their old hospital and we had no meetings in the old hospital.

Virginia Finley: Well, was most of your time spent in didactic lectures or as you say, they did give case presentations?

Dr. DiRaimondo: My time was arranged as follows. Every morning I spent half days at every hospital. I presented an hour talk in the beginning of each morning on various subjects: 1) The Treatment of Diabetes, 2) The treatment of Diabetes Mellitus, 3) The Usage of Corticosteriods, 4) The Work-Up of the Obese Patient, 5) Treatment of Diabetic Acidosis, 6) Differential Diagnosis, 7) Treatment of Hypoglycemia, 8) Treatment of Diabetes During Surgery.

Virginia Finley: Did you have a chance at any point to observe the way they were doing things or to recommend new methods to them or were they pretty much doing what they were supposed to be doing?

Dr. DiRaimondo: Only in so far as related to the different patients they presented. Each session I had, they usually presented two or three patients with various endocrine disturbances. These patients included thyroid problems, pituitary problems, diabetic problems. These are the problems which they showed me primarily. I felt that they did a reasonable job in terms of working with them. Now the group, although composed primarily of general practitioners, also included some specialists, internists, surgeons, ob-gyn people, pathologists. A pathologist was primarily responsible for the program.

Virginia Finley: Dr. Sargeant.

Dr. DiRaimondo: Yes, Dr. Sargeant, but there were no house staff members.

Virginia Finley: Oh, there weren't? How many would you say on the average at each meeting?

Dr. DiRaimondo: The attendance was surprising as they had the doctors from all three of these communities, from each of these hospitals and at some time or other the people were coming in for an hour or two and then having to leave then coming back, But the attendance I would say was somewhere between 20 and 30 people, which is very good.

Virginia Finley: Doctor, one thing we wanted to take a look at if we get continuing funding for next year is some method of finding out just who is attending by having somebody responsible there for keeping track.

Dr. DiRaimondo: In a given hospital or a given area this can be done by the local people themselves and I understand this particular group, they were assessed a certain amount of money they contributed to the total program. I think this sort of stimulated them.

Virginia Finley: As far as the two communities which you visited...which method would seem to be better. Involving the three hospitals coming to a given place for each meeting rather than the other way around. Which method would you say would be the better?

Dr. DiRaimondo: Oh, I think it is better to go to each of the areas because you can cover more people. One of the problems in dealing with the teaching practitioners---who are busy practicing and you are trying to teach them during a period in which they are operating out of their offices and so forth---is that they can't shut down their offices. But they're not far enough away ... that they could take out one hour here or two hours [and still] continue with their practice and commitments.

Virginia Finley: Was this very well organized? I take it from what I've heard that they did have it pretty much . . . .

Dr. DiRaimondo: It was well organized.

Virginia Finley: Would you make any recommendations as to what they might have done or that they didn't do or vice versa?

Dr. DiRaimondo: I think that the group in Visalia were a little self-conscious about their old hospital. They would have planned to have patients presented in their own hospital. But they did spend time in preparing protocols covering the patients that they were presenting and the doctors volunteered in terms of the patients they wanted to present and discuss. Usually, since these are basically private physicians, many were a little reluctant to present their patients for fear of being critized by some other people. Other local physicians who would be looking over his shoulder and so in a way this is a little of a problem.

Virginia Finley: Did you have an opportunity at all to observe their record keeping or charting or anything of this nature?

Dr. DiRaimondo: No.

PHYSCIANS-IN-RESIDENCE

Robert C. Lim, Jr., M.D.
San Luis Obispo, March 20-22, 1969

CONFIDENTIAL

Level of Practice: The level of practice was very good in the area of San Luis Obispo, but of course in outlying areas it's serviced by general practitioners. Right in San Luis Obispo, it seems to be very well represented by specialists in different fields. They have very good specialists coverage in that area.

Weaknesses of Practices: I don't see any definite weakness that I can put my finger on, just from my brief visit. They have a small community, and a fairly good size number of doctors taking care of that community. As far as numbers are concerned, I think that is no problem. As far as coverage of the different areas, they're pretty well manned.

Strengths of Practice: One advantage that San Luis Obispo has is that it's midway point between Los Angeles and San Francisco. In their staff meetings, they do invite people who are from the Universities in these two areas. I attended one of their medical staff meetings in one of the private hospitals. They had a professor of surgery talking to them about stroke who is connected with USC. They are pretty well geared to that; that's one of their strong points.

Areas of Potential Improvement: They are a little behind as far as patient care in terms of the specifics; namely a coronary care unit or monitoring a patient and the use of the latest laboratory facilities. This can be improved on, namely the blood-gas monitoring.

The patients are pretty-well cared for there. I was very impressed with their small unit, where they are doing hemodialysis for renal failure. Administratively, Dr. Ackray is a very capable individual. There is a good liaison also between hospital administration and the medical staff at large.

Problems of the Community: I didn't see any problems. Most of the patients are under private care. The County Hospital in itself, the clinic patient load is low, and most of the patients that used to be cared for by the General hospital, are now cared for by private doctors under Medi-Cal.

Referral Services: They handle most of their patients there by themselves. One area that I did not delve into and I don't know very much about is the care of their terminal cancer patients. I don't know if they have a unit for X-ray therapy or so forth.

Recommendations as to how the Medical Center can meet the educational needs of the Physicians & Community: If we make ourselves available to their meetings, and participate in discussions of different medical problems; it would help them a lot. I noticed that a lot of the doctors are very busy, and not all of them attended our sessions. We did get a fairly good representation. In our morning rounds, we had 5 doctors that we went around to see patients with. The first afternoon session, we had 3 doctors. For our afternoon session, we had five. I visited one of the private hospitals for their medical staff meeting the first evening I was there.

For that particular size community, I think that a one day session would be best. All the doctors can't break away for a two-day meeting, especially from their busy practice. A session in the morning and in the afternoon would fill their needs, rather than having a two-day session. I enjoyed it very much; the people were very hospitable. I think they did gain something out of my visit, at least I hope they did. They were prepared for their rounds; they had their patients together. As far as general discussion, I don't think they made any preparations, but many of their questions were very pertinent. I was very pleased.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
COMMUNITY MENTAL HEALTH SERVICES

CENTER for SPECIAL PROBLEMS
2107 Van Ness Avenue
San Francisco, Calif. 94109

May 20, 1969

L. S. Kimbrough, M.D.
Project Officer
Department of Continuing Education
University of California Medical Center
San Francisco, California 94122

Dear Dr. Kimbrough:

This is the report of my recent visit as Physician-In-Residence to the Watsonville Community Hospital May 15 - 17.

It appears to me that there is great variation in the level of clinical practice. From the nature of the questions asked at my seminars, it was quite apparent that some physicians were practicing the highest caliber of medicine while others were essentially in the dark ages. In general, it seemed that the older physicians were less well informed than their younger counterparts.

Areas of potential improvement from a psychiatric standpoint would include teaching the local practitioners more simple crisis intervention techniques. Basically, these men are clinicans and my lectures and seminars approached psychiatry from a clinical standpoint. They need to become more familiar with the various psychopharmacologic drugs and their uses. However, from the percent of participation, I conclude that they are most interested in learning and have a sincere desire to improve their clinical skills.

The major problem areas in the community are represented by drug abuse in youth and ways of dealing with it, psychoses and mental disorders in the Mexican-American population and frustration with their inability to deal with chronic alcoholism.

Ancillary services are greatly limited and deficient. Resources often exist at great distances and are not readily available to the patient population. Comprehensive psychology and social work services were not available. The entire community was served by one half-time psychiatrist.

My recommendations for furthering the education of the physicians in this community would certainly include continued participation in the Physicians-In-Residence Program. Certainly a clinically oriented professor representing the various major specialties ought to be dispatched to Watsonville at least quarterly. I would be most pleased to offer my services in this program at any future date (providing adequate notice were given). Another suggestion might be to bring various Watsonville physicians to San Francisco for intensive clinical orientation and training.

I did not have occasion to observe charts. On the day prior to my arrival, the AMA - AHA Accreditation Committee had made its annual inspection and the house staff was most resistent to any further record reviews.

My experience in Watsonville was rewarding. The staff physicians were most accomodating, interested and pleasant. I enjoyed my association with them and I hope my presence was beneficial. Thank you for this opportunity to participate in the Physicians-In-Residence Program.

Sincerely yours,

Barry S. Ramer, M.D.
Director

BSR:dyr

Report on PHYSICIANS-IN-RESIDENCE Program

Merced General Hospital, Merced
March 26-28, 1969
Edward H. Strisower, M.D.

CONFIDENTIAL

Finley: Briefly, what do you feel is the level of practice in the community hospital?

Dr. Strisower: I felt that it was fairly high. We examined about a dozen patients and I think that the individual physicians that I met were pretty well up on things.

Finley: What did you feel were some of the weaknesses and strengths of the practice, as far as you could observe?

Dr. Strisower: I think many of these questions you are going to ask me I won't have much to say because the visit was not primarily oriented to checking the practice; but from the questions and consultations, I would say they have a fair knowledge. I think they might benefit from, and they expressed interest in further meetings like the one I presented for them where they can be involved and informed of the recent advances in various areas of medicine and practice. One of the weaknesses is that most of the doctors are so busy that they feel they really can't afford to spend their time in educational research. This is the thing that cuts into the attendance at the lectures and rounds. I think they could be motivated to attend maybe if they were to receive some type of credit.

Finley: You said you did some didactic lecturing but you did some ward rounds as well, is that correct?

Dr. Strisower: Yes, I gave about 4 talks. They had a clinic one afternoon where I saw about 4 or 5 patients in hospital and then I went and saw several private patients with several doctors. I also visited two other clinics and saw several patients.

Finley: As far as you could determine, were they handling them fairly well?

Dr. Strisower: I think by-and-large that they were handling them fairly well. In one of the hospitals they were building a coronary care unit that will be fairly large and reasonably well epuipped.

Finley: Did you make specific recommendations to them as to what they might do to improve the medical care in the hospital?

Strisower: No, I didn't. I didn't really feel that on such a relatively short visit that I should make general statements as to how they should run their practice. They seem pretty well set to run their own practice in their own way and they seem to make use of existing facilities which seem fairly good. They are starting an isotope laboratory. They will be able to do some fairly sophisticated isotope studies.

Finley: What would you say could be done to improve the care in the hospital from both the clinical and the administrative point of view?

Dr. Strisower: I think all the doctors could benefit from some sort of educational program which they would attend. Some of the doctors came from out-lying places; at least one came from 30 or 40 miles away.

Finley: Do you know where or what hospital they were from?

Dr. Strisower: It was a tiny town that I never heard of. One was a surgeon. He attended the 7:00 meeting and he really seemed interested. He was obviously worn out, but he came. Some of the ones that made rounds with me in the morning told me that because of their practices they would not be able to attend until the next morning at the breakfast lecture. I don't think the attendance means they are not interested; the people who showed up seemed to be very interested.

Finley: Did you notice any problem areas in the community itself?

Dr. Strisower: You mean in medical care, social and economic problems?

Finley: Right.

Dr. Strisower: Most of the community is not terribly prosperous. They don't have any industry to speak of. Most of their sustenance comes from agriculture. They have a fair amount of competition (a much larger hospital and more elaborate medical facilities in Modesto). They seem to send problems there.

Finley: Yes, I was just about to ask you about their referral service. Do they try to handle all their patients there or do they refer?

Dr. Strisower: No, I think when they have problems they refer them to some specialist in Modesto but I don't know that they go much beyond that.

Finley: What about any recommendations you could make as to how the U.C. Medical Center can best meet the educational needs of the physician in the community itself?

Dr. Strisower: I think programs like the one in which I participated are appreciated and moderately well attended. The thing that limits attendance is the fact that some of these people are in private practice and don't feel they can leave. If they received some credit or some accreditation for attending these, that might help.

Finley: Can you tell me how many you had for your sessions on an average?

Dr. Strisower: It varied very widely. We had a good crowd at the one big meeting that was the county society meeting. I think there were 30 or 40 there but it was their regular meeting anyhow. The other things that were strickly educational varied from a low of 4 to 12 or 14. I saw them 3 times a day for 2 days and in addition to that 6 contacts with groups and in the afternoon I made rounds.

Report of PHYSCIANS-IN-RESIDENCE Program
M. Michael Thaler, M.D.
General Hospital of Monterey County, Salinas
March 26-28, 1969

CONFIDENTIAL

Finley: What would you judge the level of practice in the community hospital to be?

Dr. Thaler: As far as the level of practice, of course, that's difficult for me to judge as only a few people came and obviously its the people who are interested. I would say the level is at least average based on the people I talked with. There were a couple of outstanding individuals, who would be perfectly at home in any university setting.

Finley: What about the weaknesses and strengths as far as the practice is concerned?

Dr. Thaler: I can only judge as a pediatrician. I think as a pediatrician, there probably isn't enough coverage in that hospital for pediatric cases, inpatients, etc. They have a very good doctor there on half time who happened to have been chief resident in pediatrics last year at San Francisco General. She told me that she's actually overloaded; she's half days and she's staying longer and longer and longer because she's the only one there; and I can't imagine what they were doing before she came. General Hospital is the county hospital of Monterey County. So they do have or gather a fairly large population of service patients and, of course, everyone is in private practice and they don't have much of a coverage in the hospital during the day, in the nursery, etc. Dr. LaSalle is very good except that she's only half time.

Finley: What about the strengths? Do they seem to be handling pretty much all the cases that they should be? Is there much referral? Do they try to handle all cases themselves?

Dr. Thaler: They do refer; they refer to Stanford a lot--they're close there. And, of course, we get some occasional patients from some of the people who went through here--we get occasional referrals from them. But Stanford is closer so its more convenient; but they do definitely refer quite a bit. In fact, there was a liver transplant just performed on a baby the first one here that came from that area. It happened this patient was mentioned to me while I was there, but the doctor who had this patient actually had gotten in touch with people here while I was there before he knew I was coming and the baby was sent here the very day I arrived there.

Finley: Did you have any chance to make any sort of recommendations to them or talk to them about any suggestions that you might make as to potential improvement on what they were doing?

Dr. Thaler: Actually seeing that Dr. LaSalle, who just finished a residency at our hospital was there, was doing all the suggesting and she was finding some good reception and some very poor reception depending on how major the changes were that were suggested. So I'm not going to rock that boat any further. No point anyway, regardless of how imperfect or competent the physician. She is, as I said, the only pediatrician we have to handle the problems in the hospital. So she, for instance, is just setting up a light therapy thing, in the nursery for babies with jaundice...which they had not been doing before; but that's not unusual--that's a relatively recent development.

I certainly wouldn't be the one to suggest things to them, as I said most of these people are in private practice and they send their patients to the hospital, they attend some meetings here and there but their primary concern is with their practice rather than the hospital and I think that is perhaps the weakest part of that.

Finley: Could you tell me, do you know what could be done to improve the medical care in the hospital both clinically and administratively? Do they have a very strong administrator down there?

Dr. Thaler: Well, apparently, yes. I think its Dr. Leonard. He seemed to be well in control. It's almost impossible for me to judge in this brief three day visit. They seem to be building and their facilities seem to be expanding and that's all I can judge. Of course, I come from a university place where we have a staff man for every bed, so to speak. Its a little difficult to be objective.

Finley: Did you notice any problem areas in the community itself as far as the patients waiting too long before they go to a doctor?

Dr. Thaler: It seems to be covered fairly well. There are several practicing pediatricians in Salinas and also in Monterey. I only met one person who came in from Monterey and that was quite a sacrifice, because that is quite a ways out. The people there were honestly very busy, and that is why they would just come and go and I would meet some one day and then never see them again. There was a new bunch the next day.

Finley: What was the average attendance:

Dr. Thaler: About thirty people. A large percentage of those were nursing staff.

Finley: It was not just physicians?

Dr. Thaler: No it certainly was not just physicians. It was the nursing staff, I guess the allied health professions play a much larger role in running the hospital and patient care than they do here. I noticed that two surgeons attended several of the meetings. One cancelled his appointments and came; and another would come and go while he was doing O R work. He was always in a scrub suit.

Finley: What recommendations would you suggest as to methods by which the Medical Center could best meet the educational needs of the physicians in the community?

Dr. Thaler: I think this program is probably a good start, by having some people come out to talk to them about various aspects of disease. Stanford is really very close. Anything that the Medical Center would want to contribute would probably be more convenient or more sensible to do at the closest university. I was thinking of things like rotating residents through, but that would be rather difficult for us. Sending down physicians, sure and perhaps rotating some people through; but that is an entire area that is just beginning to be developed. The idea of taking electives in hospitals in smaller towns for a reference. They seem to be fairly well equipped and there is no problem there.

Finley: Did they give you any case presentations? Did you have a chance to look at their charting?

Dr. Thaler: Yes, they seem to be doing it quite well, up to standard. The information was there. The lab tests weren't perhaps quite as extensive or sophisticated as the one's we are capable of doing, but certainly the standard things are there and they are capable of doing them when they have to.

Finley: Did you have a chance to observe their morbidity or mortality rate.

Dr. Thaler: No. I was presented some fairly interesting patients and interesting ones from the nursery and from the outpatient department. I talked to some of the individuals and answered questions, etc. Judging from the level of the questions, the types of cases, and discussion, I would say that the people know what they are doing.

Finley: Did you notice anything as far as vocabulary, communications? Did you draw from any other of the hospitals in the area besides Salinas?

Dr. Thaler: As far as I know, no. Of course, there might have been some individuals from some other places and I wouldn't have known that but as far as

I know, no. I did notice only one person from Monterey since this is supposed to be the county hospital for this area. I guess Monterey is a rather special example. It is a rather rich community compared with Salinas and they probably have some older pediatricians who are well established and perhaps arennot quite as interested in going to academic meetings and that kind of thing.

Finley: Was it well organized from your standpoint? Were you warmly received?

Dr. Thaler: I was very warmly received. I also received a very nice follow-up letter thanking me. The facilities, they were building at the time. They did the best they could and those are problems that they are quite aware of themselves. They have to make do with the temporary quarters for presenting their cases and lectures, because they are awaiting new quarters.

PHYSCIANS-IN-RESIDENCE

Roger H. L. Wilson, M.D.
Tulare County, May 13-15, 1969

CONFIDENTIAL

Introduction

In order to assess areas of success or failure of the program on a representative basis, it was decided that a second period as Physician-in-Residence in the field of pulmonary disease in the Tulare County area would be desirable. The organizers of the program felt that this best would be achieved by spending a full day each in the communities of Exeter, Porterville, and Tulare. In addition, I also attended the tumor board at Visalia and a meeting of the Tulare County Medical Society Committee, which was the local supervisor of the program. My itinerary during this period was:

PROGRAM

Tuesday May 13, 1969	KAWEAH DELTA REGIONAL TUMOR BOARD, VISALIA (Basement of 222 W. Willow, across the street from hospital)
8:00 - 9:00 A.M.	Several cases of carcinoma of the lung
	Guest Discussant - Dr. Wilson
	SIERRA VIEW DISTRICT HOSPITAL, PORTERVILLE
10:00 - 12:00 Noon	Case Presentation and Rounds
12:30 - 1:30 P.M.	Lecture - Evaluation of Respiratory Status of the pre-Op Patient; Respiratory Care of the post-Op Patient.
2:00 - 4:00 P.M.	Case Presentation and Rounds

5:00 P.M.	Lecture - Pulmonary Function and Blood Cases; Their Clinical Application
Wednesday May 14, 1969	EXETER MEMORIAL HOSPITAL, EXETER, CALIFORNIA
10:00 - 12:00 Noon	Case Presentations and Rounds
12:30 - 1:30 P.M.	Lecture: Pulmonary Infarctions
2:00 - 4:00 P.M.	Case presentation and rounds
7:30 - 8:00 P.M.	Lecture: Pulmonary Emphysema
Thursday May 15, 1969	TULARE GENERAL HOSPITAL, TULARE, CALIFORNIA
8:00 - 9:00 A.M.	Lecture - Post Operative and Post Traumatic Pulmonary Insufficiency, Diagnosis and Treatment
9:30 - 11:30 A.M.	Case Presentations and Rounds
12:30 - 1:30 P.M.	Lecture: Pneumonias - Bacterial, Fungal and Viral
2:00 - 4:00 P.M.	Case Presentations and Rounds

My general impression of the program in the communities visited is that a great deal has been accomplished in terms of physicians' interest and positive achievement since October 1968. For the purposes of completeness I shall give a general narrative discussion followed by a list of the positive points that I feel merit particular scrutiny.

Progress Report

The tumor board in Visalia is a new institution meeting regularly, and which received a great deal of impetus in its development from the previous visits of Dr. Richard Lyons to Exeter. Forty-two physicians participated in the meeting which concentrated on the problems of earlier diagnosis and therapy of the commonest male tumor.

It seems quite clear that Visalia is undergoing considerable change in the nature of medical practice. A new hospital has been built and will shortly be opened containing far better facilities than the present one. There has been a definite move toward the development of local specialty interests and my impression was that we were seeing a cohesive community with a real interest in the development of its own education. I noted that a number of the physicians from other towns were present, including Tulare, Exeter, Lindsay and Porterville. The discussion was informal and stayed at a very lively pace. Six cases of varying stages of the disease were presented by the physicians looking after them. This was not a lecture type tumor board, in which the pathologist, radiologist and surgeon did all the work. The visual equipment was of a high order, with a projecting microscope recently purchased of particular high quality. What impressed me most, however, was that there was an attitude that these cases were being presented not so much for their individual solution and best management, but in terms of the disease process itself and the overall problems in diagnosis and therapy.

Following the tumor board, I visited Sierra View District Hospital at Porterville. During the day I was exposed to about 40 physicians, including about 15 or 20 from other Tulare County communities. The case material presented was divided about equally between problems in diagnosis and management of pulmonary disease and the specific problems of respiratory failure. Technicians were present during the latter discussions, since they intend to set up modern blood gas analysis equipment in the very near future together with the kind of spirography etc. described in the protocols issued in October 1968. I should point out at this time that the pathology services for Porterville, Exeter, Tulare District and part of Visalia are run by the technician who attended the discussions. Those protocols were distributed county-wide. As noted in my previous report many physicians use both Porterville and Exeter and to some extent Visalia, although naturally in his day by day office practice a physician may specifically be in one geographical locality. This visit to Porterville is part of a new format adopted at the urging of the Tulare County Medical Society Committee, which has adopted the local role in this project. Much of the strength in this 42 bed hospital, which is insufficient for the needs of its populace, appears to be coming from three individuals: a radiologist, primarily assigned to that hospital but working as well in various county activities such as the Visalia Tumor Board; the surgeon, who was Chief of Staff at Exeter at the time of my last visit. It is clear that the interrelationships between these small hospitals is largely due to these men and that a truly cooperative effort is being extended toward coping with the very major problem of hospital care in these communities.

The following day was spent entirely at Exeter where I was exposed to approximately 25 physicians. As seen in the program above, very specific case problems were brought up for discussion, and as at Porterville, actual patients were presented. However, I found some startling and really gratifying changes had occurred. Since the previous P-I-R visit, blood gas equipment had been purchased and had been operational for approximately three months. Two of the patients presented were still in the hospital. In these cases, life-saving procedures were promptly put into effect, unquestionably because prompt recognition of severe respiratory insufficiency with acidosis was thought of clinically and confirmed by immediate laboratory study. I would like to spend a moment on these two cases together with a third one.

A young aviator whose plane crashed was taken to Lindsay with severe chest injuries. At Lindsay the collapse of one lung was noticed and immediately treated; however, his state of consciousness was felt to be unsatisfactory and he was promptly transferred to Exeter. At Exeter a combined approach with a general physician doing surgery with his surgical competitor, the anesthesiologist and the pathologist immediately established the peril which was imminent. The patient was intubated, a procedure not formerly being done in this hospital, and artificially ventilated while monitoring the arterial carbon dioxide pressure. He is now doing splendidly.

The second case was a woman of about 50, very obese, who failed to recover to the level of consciousness quite expected following hip surgery. A blood gas was drawn, she was found to be severely acidotic and she was intubated. Her ventilation was corrected to the necessary level and maintained over the next day or two until she was able to control this herself. Neither of these cases had completely smooth clinical courses and much of the discussion time was spent in such problems as electrolyte control, potassium therapy, the dangers of over ventilation and careful scrutiny of the metabolic side of the complications in their clinical course. However, unquestionably their lives were saved and we can anticipate that future cases will go more smoothly.

I was told that there had been other similar situations; but since these patients were in the hospital and were still recent in everybody's minds, they were used as examples of the kind of work that was being done.

A third patient was presented to me in chronic acidosis with heart failure, etc. The purpose of presenting this patient was to outline in detail the management of this very serious common problem seen in pulmonary emphysema. The plan was to hospitalize him and carry out relief of a life-threatening situation. The day after my return, the physician in charge of the case telephoned me and indeed he was progressing exceedingly well.

You will note that two lectures were scheduled to be given at Exeter; however, the physicians requested that the original titles, which had been somewhat randomly chosen, be altered to the problems of first, Acute Respiratory Failure and secondly, Chronic Respiratory Failure using these actual patients as examples. The physicians involved presented these and a most animated seminar discussion resulted at noon and in the evening. It is quite clear that the consciousness and ability to handle these kinds of patients represents an important area in which therapy is so often inadequate. This was indeed the spearhead of my previous session in

October of 1968, and the whole approach is very different now in this community. Again, physicians from Porterville, Lindsay, Visalia and Tulare attended.

It should be remembered that Exeter is actually at the moment the largest hospital of the area with 70 beds. Lindsay, the smallest of the three hospitals, transfers most of its difficult cases. It is expected that Porterville will model itself on what is being done at Exeter. However, much more has been achieved. Three weeks prior to my visit, a laboratory assistant was hired for the specific purpose of doing pulmonary function testing. Mrs. Wilson, who works with me in my laboratory at the University of California, spent the entire day doing tests, showing the laboratory assistant how to interpret them, and by the end of the day was completely satisfied that she was competent in spirography. She is to be sent up to my laboratory for 48 hours in the near future to be trained in equalibration carbon dioxide analysis, since for following patients who are in difficulties, this does not require the use of arterial blood and can be done frequently in an area where physicians are at a premium (1 to every 1430 people).

In my previous report there was some discussion of an intensive care unit of modified type. Two nurses, who will work in this unit, have already been sent away for intensive care training and a three-bed ward has been selected, equipment ordered for just the type of modified intensive care unit possible in a hospital this size, but representing a very marked improvement of potential patient care. It appears that some of the delay on this was related to problems of building code which have been solved.

There were many other examples of changes in the approach to physician care. A patient with pulmonary infarction, as it subsequently turned out, was immediately heparinized before the difinitive diagnosis could be made, again a potentially life saving situation; and I found an enormous increase of interest both in the immediacy and appropriateness of diagnostic and therapeutic effort, which differs greatly even over such a short period of eight months.

Thursday was spent at the Tulare County Hospital in Tulare. This was a departure from the original scheme of the Physician-in-Residence Program, but was arrived at by the Tulare County Medical Society Committee in view of the tremendous scattering of centers throughout a rather large county and because of the very real problems in pulmonary disease encountered at this hospital. This is a 98-bed hospital essentially serving the indigent of the county. As might be expected it is bilingual with all signs in Spanish as well as English. The other hospital in Tulare, the District Hospital, is nearly the same size, but its occupancy rate is quite low. The problems encountered by the Tulare County Hospital at an administrative level seem sufficiently important to be discussed in detail.

Although with the advent of Medicare this became an open staff hospital, in fact only two surgeons and one general practitioner/internist has used the hospital in the last year and a half. There is a full time staff of

12 physicians representing the major specialties and general medicine. The maximum salary is $2,000.00 a month and this is a recent rise in pay. My first impression was that staff turnover was exceedingly rapid and that to obtain really good men with a stake in the community was almost impossible. At one point in the last five years the medical staff was as low as two physicians. The medical director is a career man with a real stake in good medicine; however, one of the results of this rapid turnover is that the association of the other physicians in the community with the county hospital leaves much to be desired. Part of this may be felt to be on a competitive basis but I suspect that a major aspect is the lack of identification between physicians in Tulare proper and those in surrounding areas. There are other consequences of this. The county hospital, for example, has the only good small library with periodicals etc. that I saw. This, however, is not used at all by the physicians in Tulare. Doctor Bifulco informed me, moreover, that there is a considerable move afoot by the county supervisors to close this hospital. This would put tremendous pressure on the other hospital and would leave a considerable problem of the large outpatient clinic population which they at present care for on a county wide basis. This presumably, if it occurred, would be financed on a tax support basis which already functions on the East side of the county. While all of the physicians at the county hospital attended the sessions there, only four from outside came to the lunch meeting. I feel that there is a certain isolation from the main stream of the medical community which has been seen in other county institutions.

The hospital is well equipped and has followed the lead given by Exeter in the development of blood gas analysis, but is not at present doing spirography or other tests of pulmonary function. While these have been put in next year's budget, there is no surety that this will go through. Moreover, with the relative mobility of the staff it seems clear that differing practices in the management of specific situations are likely to succeed each other, which again mitigates against the kind of community development which seems most desirable.

This is somewhat parallel to the situation described by Dr. Reider in his visit to Salinas. He found much excellent practice but divorced from the medical community. Similar problems were found in Stockton where the San Joaquin County Hospital was abandoned as a meeting site on just this kind of basis. It appears that the transition from county hospital to community hospital is not proving to be a very smooth one in California. However, this does offer a challenge to the Physician-in-Residence Program in that there is some evidence that it acts to some extent as a catalyst bringing these two separate medical communities together.

The evening after my arrival I met with the education committee of the Tulare County Medical Society. I was impressed by their enthusiasm for this program and we discussed in some detail the change in format which they felt to be desirable. They expressed again, as they had previously, the fact that cross-fertilization in the northern part of the county is commonplace partly as a result of the distribution of facilities. Among the facts which they brought out most importantly were: 1) That Visalia, Exeter, Lindsay and Porterville essentially function as a unit with some definite spillover from Visalia and Tulare. 2) The fact that Exeter, although a very small town, contained facilities not available in some of the other communities, together with an excess of hospital beds. This made it a natural focal point for physicians particularly in Lindsay and Porterville who use it frequently. 3) That for the physician in Porterville to go as far as Exeter to participate in the program, although he might well have patients in Exeter Hospital, was difficult, and that essentially we should think of Porterville as an extension of the whole area. 4) That it might be well to consider revisiting more frequently on the basis of all these communities rather than doing it in a single three-day visit.

It appeared to me that these were very good arguments and at least on an experimental basis we were justified in examining this as we had done in Modesto where a somewhat similar situation applies but with less geographical spread. Initially, it was decided to try three such sessions of which mine was the second and it appears that the participation certainly warrants the consideration of the Eastern section at least as one and that the Western section also fits in via Visalia and Exeter.

They are presently considering nine visits during a year part of which they are to pay for. There is a suggested order of priority and tentative locations drawn up. Six hospitals are to be used, including both Tulare hospitals, Visalia, Lindsay, Porterville and Dinuba, a community with a 51 bed hospital and more limited development than the others. The tentative areas would be chest disease (at this visit), cardiology, metabolic disease, psychiatry, infectious disease, renal disease and hypertension, obstetrics and gynecology, chest surgery and trauma, and oncology. This is a very broad program, and would combine remarkably well with what has already been achieved.

SUMMARY

1) A change of format was used for this visit in which Tulare County was considered as a single unit. 2) Participation included about nearly half the physicians in the county. 3) The lively self-involving clinically oriented sessions were immensely well organized and personal contact with the physicians was maximal. 4) There is clear evidence that life saving and therapeutic procedures have been adopted as a result of my prior visit. 5) There is a clear spillover of the same kind of management into the two other hospitals involved, particularly Porterville. 6) There is a manifest increase in concern and interest in continuing education as such. 7) Moves have been made toward the development of modified intensive care, and training is under way.

All in all, I came away with evidence that this program was gaining momentum, had become increasingly acceptable to the physicians in the area; and lastly that real therapeutic advance has been made in this extended community.

TULARE COUN EDICAL SOCIETY
P. O X 16
1640 W. MINER NG - SUITE 202
VISALIA, C RNIA 93277
73 6

EDUCATION
1969 JAN 21 AM 8 46

January 20, 1969

Roger Wilson, M.D.
University of California
School of Medicine
3rd and Parnessus
San Francisco, California 94122

Dear Doctor Wilson:

I want to thank you for extending to me the opportunity to meet with you on January 9th concerning the visiting professor program as it relates to Tulare County. As I stated at that time, we in Tulare County are most enthusiastic about this program. The pilot study done at Exeter and Tulare County Hospital was certainly received with much enthusiasm. Though the number of people attending was perhaps not as great as was hoped for, certainly the enthusiasm was there. I was very happy to hear that you as the teachers of medicine were as enthusiastic about coming to Tulare for these teaching sessions as well. On a county basis we are extremely interested in continuing this program.

I am in the process at the present time of contacting staff presidents of the hospitals in our county in an attempt to see what can be done about working out the finances of this program. We have an ongoing committee, three of the members of whom will be meeting with you on January 25th. At that time we hope to/have a beginning idea of how the program can be carried out, specifically with the most effective teaching and the least amount of time expended by the professors as well as by those being educated.

Thank you again for promoting this program in our county and helping us bring good medicine to a small community.

Sincerely,

G. J. Tiss MD

George J. Tiss, M.D.
President

GJT:cvs

ADDENDUM D

SYNOPSIS OF PHYSICIANS BY GEOGRAPHICAL AREA

AREA	Number of Physicians	Average Age	Percent Calif. Graduates	Percent America Board Specialti
Chico	71	51	33%	30%
Exeter	13	51	23%	38%
Marysville	46	54	28%	39%
Merced	44	44	21%	25%
Modesto	163	52	41%	39%
Redding	71	51	38%	41%
Reno	153	54	21%	48%
Salinas	91	52	34%	36%
San Luis Obispo	68	53	18%	54%
Stockton	274	52	36%	32%
Tulare	31	52	26%	16%
Ukiah	39	55	38%	36%
Watsonville	37	55	41%	16%
TOTAL	1,101	52	31%	34%

NOTE: The above figures are for the specific communities where we have a participating hospital, and do not reflect the surrounding drawing areas.

PHYSICIANS-IN-RESIDENCE PROGRAM

FINAL REPORT

PH #108-68-12

VT011201

136

TABLE OF CONTENTS

Page

SUMMARY 1

I METHODOLOGY OF THE PROGRAM 3

- Selection of Fourteen Hospitals 3
- Aims of Program 11
- Selection of Instructors 15
- Programs at Participating Hospitals 16
- Utilization of Manpower 24
- Special Problems and Recommendations 26

II EVALUATION 29

- Variable to be Evaluated 30
- Data Analysis 32

III ACCOMPLISHMENT OF GOALS 34

CONCLUSIONS 36

ADDENDUM A LIST OF HOSPITAL KEY CONTACTS AND FACULTY

ADDENDUM B PHYSICIANS-IN-RESIDENCE

APPENDIX A INDIVIDUAL PIR INTERVIEWS

APPENDIX B COMMENTS FROM KEY HOSPITAL CONTACTS

ATTACHMENT I EVALUATION CONFERENCE PROCEEDINGS

VT011201

U.S. DEPARTMENT OF HEALTH, EDUCATION
& WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

137

February 20, 1969

PHYSICIANS-IN-RESIDENCE PROGRAM

FINAL REPORT

PH#108-68-12

SUMMARY

Goals

1. To develop a demonstration project of Physicians-in-Residence (PIR) in fourteen communities in Northern and Central California, and Reno, Nevada, for the continuing education of practicing physicians in these communities.
2. To implement the project as follows:
    a. select ten to fourteen community hospitals in different cities in the above named regions.
    b. with representatives of the hospital's staff in cities selected, determine the most urgent educational needs of the medical staff of each hospital.
    c. select and assign medical faculty from the University of California, who can most effectively teach in the identified areas of greatest need, and visit each selected hospital for a three-day period, in which to accomplish this teaching.
    d. each physician-in-residence to provide to the PIR Project Director a detailed report of his visit.
3. At the end of the program, a conference between the Continuing Education staff, physicians-in-residence, and representatives of each community hospital will be held to discuss the impact and the effectiveness of

this type of educational program in relation to the total educational activities of the practicing physicians.

Accomplishments

1. The selection and cooperation of fourteen community hospitals in different cities. (See pages 3 thru 10).
2. The Project Director and Hospital Liaison have worked closely with the hospital staffs, the University of California Medical Center faculty, and the local medical societies to determine specific needs of the respective hospitals. (See pages 11-15).
3. At present, thirty-eight Physicians-in-Residence have been assigned to the fourteen participating hospitals. (See Addendum A).
4. Thirty interviews have been held between the Project Director, Hospital Liaison and the Physicians-in-Residence, giving candid opinions on their visits. (See Appendix A)
5. A conference between the Continuing Education staff, Physicians-in-Residence, and representatives of each community hospital was held on January 25, 1969, to determine the specific means by which the Medical Center can best serve the educational needs of the physicians of the community hospitals. (See Attachment I)

As a direct result of this year's program, there is presumptive evidence for the following:

1. The recipients of this program are unanimous in their desire to maintain and extend it.
2. The local community will accept and welcome physicians from the University.

3. In certain instances, patient care has been improved as a result of the program. (See pages 35-36).
4. In certain instances, local community physicians have begun to address themselves to the problem of how to improve use of local facilities.
5. In certain instances, increased cohesiveness of medical practice within the community has occurred. (See page 35).
6. Enthusiasm for additional locally directed in-service programs has increased.
7. Beginning efforts at local financing for such programs is occurring.
8. Closer inter-relationship between physicians in the community and academic faculty has begun.
9. New facilities and techniques previously not contemplated by the local medical community have emerged. (See page 35-36).
10. The medical school faculty involved in the program have indicated that their experiences in the communities may modify their approach toward students, residents, and fellows at the University; and this may favorably affect graduates going into the practice of community medicine.

I. METHODOLOGY OF THE PROGRAM

Selection of Fourteen Hospitals in Different Cities

As indicated in our first quarterly report, site visits were made to the fourteen hospitals selected to participate in the Physicians-in-Residence Program. The purpose of the program has been to make recent applications of research available to physicians who are otherwise unable to pursue post-graduate education because of restrictions of time and distance. As the original proposal stated:

> "The degree of sophistication in medical practice, insofar as that practice is the result of close contact with research, is understandably lessened in proportion to the distance of these communities from major urban medical centers."

The medical communities were chosen "because of their lack of specialized referral facilities and programs of Continuing Education." We also felt that the participating institutions had good potential for developing and upgrading health care facilities.

The population served by the communities selected ranges between 5,000 and up to 900,000. (These population figures include adjacent rural areas). The final selection of participating hospitals was also based on the willingness of the institutions to cooperate in the program. For example, we substituted the Watsonville Community Hospital, a new facility, for Auburn. This was done because of Auburn's inability to support a three-day program.

The hospitals were chosen in the following categories:

A. Small Towns and Surrounding Rural Areas

Exeter (Memorial Hospital): 74 beds

Exeter is a small town of 5,000 population in the San Joaquin Valley; Lindsay, Porterville, (to some extent Visalia) form a unit with Exeter. It is an agricultural community in the citrus belt of Central California, with a good deal of wealth. There are 13 doctors in the medical community, about 50% of whom are specialists. The hospital is a non-profit corporation and is sponsored, built, and promoted by a group of interested laymen. Exeter is really a neighborhood in a larger community. The larger community is Tulare County, which has a population of about 200,000. There are six private hospitals, two county hospitals and a State hospital in Tulare County with approximately 140 doctors in the County Medical Society.

Tulare (Tulare County General): 98 beds

Tulare has a population of 14,000, and like its neighbor, Exeter, is mainly agricultural. Tulare has a growing migrant population as well as a static physician population. The hospital itself is a 43-year-old antiquated building, which has been added on to within the last ten years. There are nine paid physicians on the staff; four of these are either Board certified or Board eligible. Again, there is some crossing with Visalia, but not with Exeter, Lindsay, or Porterville. Hence, the choice of two adjacent communities in one county.

Ukiah (Mendocino County Hospital): 85 beds

Ukiah is a city of approximately 10,000 people with a surrounding population of perhaps another 20,000 in Northwest California. The principal industries are largely agriculture and lumber; however, recreation and tourism are important sources of revenue to the community. A large part of the economy is based on the Mendocino State Hospital there. In Ukiah, there are four hospitals: one county, one privately owned, one non-profit corporation, and one State. There are approximately 27 doctors in Ukiah: 12 GP's and 15 specialists. Approximately thirty miles north of Ukiah in Willits, there are three GP's; 65 miles northwest in Fort Bragg, there are 6 GP's; and, in neighboring Lake County, approximately 15 GP's and no specialists.

Watsonville (Community Hospital): 86 beds

Watsonville is a rural agricultural community, located between the cities of Santa Cruz and Monterey on Monterey Bay. The city is situated on the southern boundry of Santa Cruz County with a population of about 14,000 to 15,000 people. There are several smaller areas adjacent to Watsonville, with a total population of about 35,000, which is serviced by the Community Hospital. The present hospital is approximately thirty years old; however, a new hospital is in the last stage of completion. The new hospital will have a capacity of 168 beds. There are about forty active members on the hospital staff; 26 or 27 of these practice in Watsonville, half of whom are GP's.

B. Middle-sized Towns Functioning as a Single Unit

Chico (N.T. Enloe Memorial Hospital): 92 beds

Chico is located approximately 180 miles north of San Francisco in the Sacramento Valley. It is an agricultural and college community, which serves as a distribution point to the more rural surrounding towns in the Butte-Glenn Counties. Butte County has a population of about 100,000 with approximately 120 physicians. Approximately one-fourth of these physicians are specialists and are chiefly located in Chico. There are a total of seven hospitals in Butte County: one county and the other six community hospitals.

Redding (Memorial Hospital): 132 beds

The community of Redding has about 25,000 population within its city borders and another 25,000 people in the adjacent, partially unincorporated communities. The total population of Shasta County is around 80,000, with the bulk of the people in or near Redding. Redding has developed somewhat as the medical center for several of the neighboring counties. There are two major hospitals in Redding totalling about 400 acute care beds. There are 100 members of the County Medical Society, and 70 of those are on the staff of Memorial Hospital.

Marysville (Yuba County Hospital): 78 beds

The Marysville community consists of twin cities--Marysville and Yuba City--located in Yuba and Sutter Counties. Marysville is about 120 miles north of San Francisco and has a population of 9,553; Yuba City has a population of 11,507. Each city has one private and one county hospital. There are 72 members of the Medical Society in the two counties. There are many more specialists in Marysville and Yuba City than GP's. Marysville has four GP's while Yuba City has twelve.

San Luis Obispo (County General Hospital): 206 beds

San Luis Obispo is a city of approximately 25,000 and the county seat of San Luis Obispo. The main sources of income are agriculture and tourism. The General Hospital has 206 beds--140 of which are utilized in the treatment of acute, medical, surgical and psychiatric cases. The hospital provides the only psychiatric facilities available within the county. The latter consists of a Community Mental Health Program providing an outpatient department, 26 in-patient beds and two staff psychiatrists, one GP, three nurses and eight psychiatric social workers. The remainder of the beds are divided between medicine, surgery and a small pediatric and obstetrical department. The non-psychiatric portion of the hospital is staffed by two GP's. In addition to the full-time county employees, there are 54 active medical staff members who are in private practice in the area. The attending staff is composed primarily of specialists with approximately twelve men engaged in general practice.

Salinas (General Hospital of Monterey County): 334 beds

The General Hospital of Monterey County encompasses both the Salinas and Monterey areas; these two districts are separated by about twenty miles. The Salinas area itself has approximately 75,000 people and is essentially agricultural. The Monterey Peninsula, where Salinas is located, is a resort and retirement community with a great deal of tourism. Of the 130 members of the visiting staff, half come from the Monterey Peninsula. This poses a transportation problem for local men who must make a forty mile round trip in order to attend meetings. In addition to the visiting staff, there is a good number of full and part-time staff, resident physicians and general practice for replacements.

Merced (General Hospital): 248 beds

Merced has about 30,000 people, located in the California Central Valley, and is the tenthranking agricultural county in California. A salient feature of the area is its overall economic profile: in some communities perhaps 10% of the population owns up to 75% of the total assets. This means that there are a tremendous number of people who are in the disadvantaged economic groups, which results in difficult problems in medical care. There are 120,000 people in Merced County proper, with at least 50,000 people in the contiguous areas of Madera-Mariposa-Stanislaus Counties, who look upon Merced as their shopping center and source of major medical care. There are two hospitals in Merced, neither of which has an intern or resident staff. Merced General is a community-owned hospital with about 100 active beds and another 150 specialized beds in which chronic care facilities or psychiatric beds are well represented. The other hospital is run by the

Dominican Sisters and has approximately 100 beds. During the past ten years Merced the preponderance of physician population has shifted strikingly from men in general practice to those in specialty practices.

C. Small Cities

Modesto (Scenic General Hospital): 292 beds

Modesto is the County Seat of StanislausCounty, and is situated at the northern tip of the San Joaquin Valley, 93 miles Southeast of San Francisco. There are approximately 230 industries in Stanislaus County, about 75% of which are in the Modesto area. Following agriculture and trade, manufacturing is the third largest employing group. Scenic General is a community hospital operated by Stanislaus County with 292 licensed beds: 189 acute medical-surgical beds. Scenic General has a GP Residency Training Program with seven alloted spaces (six are filled) and a Surgical Resident in third or fourth year of training from an affiliated program. The surgical resident rotates at the end of six months. The teaching staff at Scenic General consists of 105 members, all from the county. With the exception of GP's, the staff members are all Board eligible or Board qualified.

Stockton (St. Joseph's Hospital): 250 beds

Stockton is an inland seaport connected to San Francisco Bay by an 88-mile channel and by approximately 80 miles of road. Surrounding the city is a rich agricultural region; food processing and farm implement manufacturing are the chief industries. Its population of 86,321 is located in the San Joaquin County--the fourth richest county in the United States. St. Joseph's, one of Stockton's four hospitals, is a private Catholic hospital with a 150-200 active medical staff. Within the last four to five years the breakdown of physicians has shifted radically toward specialists. At present, approximately 70% of the active staff are specialists.

Eureka (General Hospital): 103 beds

Eureka is located on the Northern Coast of California, approximately 100 miles from the Oregon border. Lumbering is the largest industry in Eureka, an important and commercial center on Humboldt Bay. This harbor is the chief port between San Francisco Bay and the Columbia River. Eureka has a population of about 29,000 and three hospitals.

Reno, Nevada (Washoe Medical Center): 415 beds

Reno is approximately 225 miles Northeast of San Francisco. The Reno-Sparks area has a population of approximately 150,000, and draws upon an additional surrounding population of approximately 300,000 to 400,000 from most of Northern Nevada, the eastern slopes of the Sierras, and part of California and Lake Tahoe. This is in addition to several million tourists every year. There are four hospitals in Reno. Washoe Medical Center, which currently has 415 beds, and approximately 3,000 emergency room visits per month, plans to expand to 765 beds this summer. Washoe Medical Center does not have a house staff. The emergency room is staffed by paid physicians on a twenty-four hour basis. These are physicians who often either plan on going into practice in the community or have not been employed there and decide to do so. Through a recruitment program, they have been able to maintain an adequate level of physicians. Washoe depends a great deal on the nursing staff for such things as cardiac arrest and coronary care facility. Reno is likened to Merced in that they have effectively one medical community. There are approximately 155 physicians in active practice in town--150 of these are on the staff of two hospitals.

Aims of Program

Because this program was community based, it aimed at assisting local institutions to establish continuing education programs for local members of the health professions by taking maximum advantage of "existing medical talent and facilities as well as to inaugurate new procedures aimed at improving patient care." The ultimate goal is for the hospitals to become their own centers of continuing education, utilizing the resources of universities and medical centers. Thisis necessary to develop and sustain local programs, as well as providing continuing stimulation through new clinical and scientific advances. The specific aims were to determine:

1. areas in medicine where improved referral procedures are indicated
2. areas of sub-standard treatment;
3. medical and paramedical training needs;
4. in what areas facilities need improvements; and, since
5. evaluation is crucial to the development of community based continuing education program, specific problem areas were chosen after interviews between the project staff and representatives of community hospitals and community medical societies representatives. This was the most effective way of determining the kind of faculty required to match medical talent with the most urgent needs of hospital and community. The faculty, in their roles of Physicians-in-Residence continued to evaluate the critical areas of need in order to provide a basis for follow up of the program.

Determination of Educational Needs of Participating Hospitals

The Project Director and Hospital Liaison worked closely with the hospital staffs, the University of California Medical Center faculty, and the local medical societies to determine specific needs of the respective hospitals. In addition, liaison was maintained with other hospitals in the communities. In the first nine months of the Physicians-in-Residence Program, 33 physicians conducted programs at the following hospitals: Enloe Memorial, Chico; Memorial, Exeter; Yuba General, Marysville; Merced General, Merced; Scenic General, Modesto; Memorial, Redding; Washoe Medical Center, Reno, Nevada; General Hospital of Monterey County, Salinas; County General, San Luis Obispo; St. Joseph's, Stockton; Tulare County, Tulare; Mendocino County, Ukiah; and Watsonville Community, Watsonville.

In each instance, the specific educational needs were determined in consultation with the following key staff members of participating hospitals:

Accreditation/Type[1]	Hospital	Key Contact/Title
1, 9, 10/NP	Memorial, Exeter	Dr. Ward Evans, Chief of Staff
1, 9, 10/G	Tulare County, Tulare	Dr. Eugene Bifulco, Chief of Staff
10/G	Mendocino County, Ukiah	Dr. Frank H. Dailey, President of County Medical Society
1, 9, 10/NP	Watsonville Community, Watsonville	Dr. David Bushman, Director of Medical Education
1, 9, 10/NP	Enloe Memorial, Chico	Dr. Carlton Huitt, Chairman of Program Committee
1, 9, 10/NP	Redding Memorial,Redding	Mr. Robert A. Roberts, Administrator
10/G	Yuba County, Marysville	Dr. Joseph Salopek, Chief of Staff
1, 9, 10/G	County General, San Luis Obispo	Dr. Richard L. Anderegg, Director of Medical Services, County Hospital System
1, 2, 10/G	Merced General, Merced	Dr. John D. MacCarthy and Dr. John Anglin, Chairmen, Program Committee

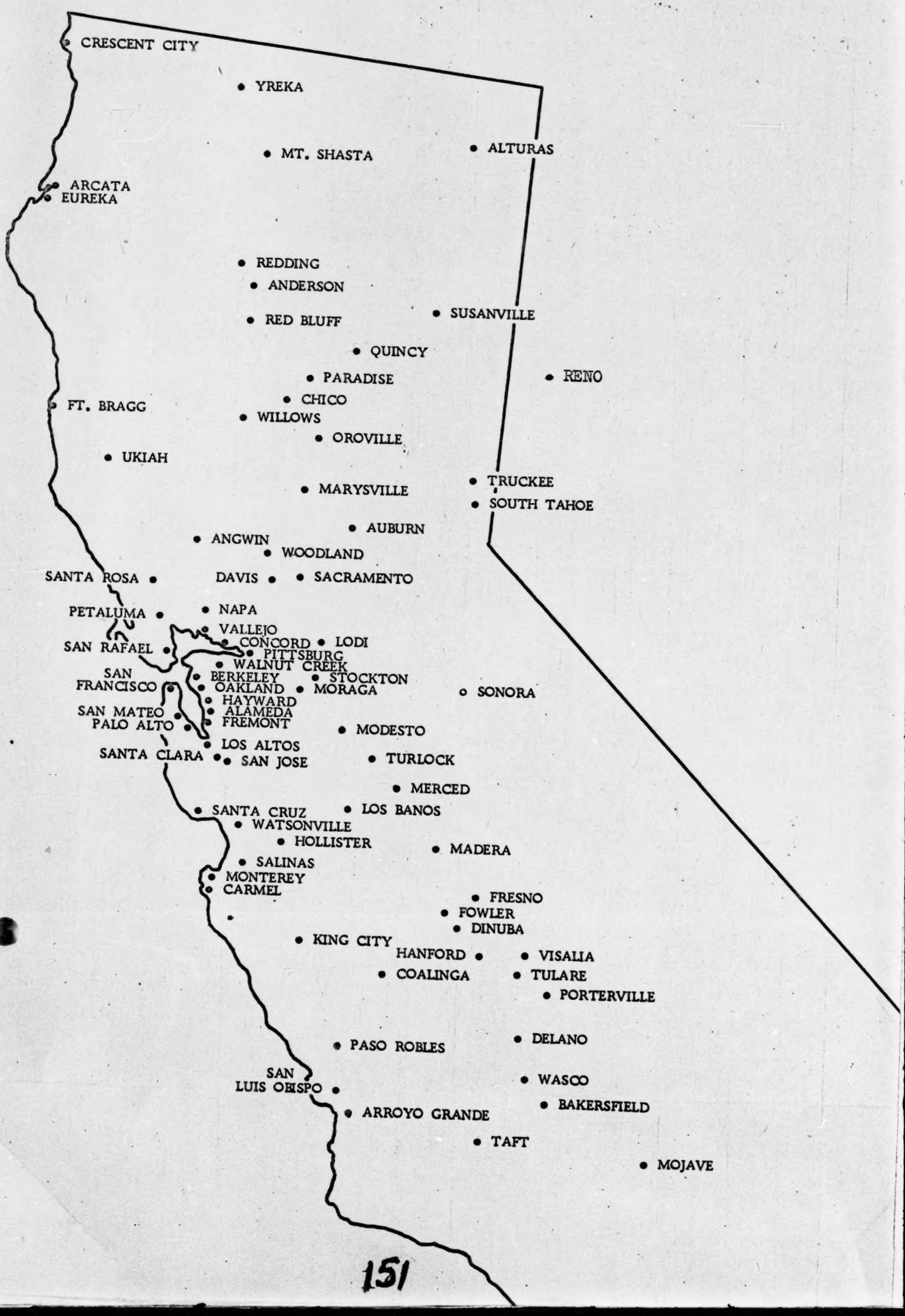
---

[1] NP non-profit voluntary hospital; G Government Hospital; CRNP Church related non-profit voluntary; 1 Joint Commission Accredited; 2 Cancer Program accredited by American College of Surgeon; 3 Approved for residency by AMA; 7 Hospital-controlled LVN school approved by state board; 9 Blue Cross-Blue Shield approved; and 10 Medicare approved.

1,2,3, 10/G	Scenic General, Modesto	Dr. William A. Todd, Director of Medical Education
1,3,10/G	General Hospital of Monterey County, Salinas	Dr. Carl J. Leonard, Director of Medical Education
1,9,10/CRNP	St. Joseph's, Stockton	Dr. J. David Bernard, Director of Medical Education Committee
1,9,10/NP	General Hospital, Eureka	Dr. Theodore Whelton, General Practice
1,2,7,9,10/G	Washoe Medical Center, Reno, Nevada	Dr. Robert J. Barnet, Program Chairman, Continuing Education Committee

While the above staff people were the principal contacts, in each instance discussions were held with other representatives of community physicians on the hospital staffs, as well as with representatives of the county medical societies. Key contact people change in planning for each PIR visit, depending on the educational problem area.

As can be seen from the accreditation code, the participating hospitals need the kind of assistance and evaluation being provided through the Physicians-in-Residence Program. Of the fourteen participating hospitals, 12 are accredited by the Joint Commission; 3 are accredited for cancer programs by the American College of Surgeons; 2 are approved for residency training by the AMA (in both cases for general practice residency); none are approved for internship by the AMA; none have medical school affiliation; none have a professional nursing school accredited by the National League of Nursing; one has a Licensed Vocational Nurse Training Program approved by the Nevada State Board of Examiners; none are members of the Council of Teaching Hospitals of the American Association of Medical Colleges; nine are approved by Blue Cross-Blue Shield, 14 are approved for medicare payments.


CRESCENT CITY
YREKA
MT. SHASTA
ALTURAS
ARCATA
EUREKA
REDDING
ANDERSON
SUSANVILLE
RED BLUFF
QUINCY
PARADISE
RENO
CHICO
FT. BRAGG
WILLOWS
OROVILLE
UKIAH
TRUCKEE
MARYSVILLE
SOUTH TAHOE
AUBURN
ANGWIN
WOODLAND
SANTA ROSA
DAVIS
SACRAMENTO
NAPA
PETALUMA
VALLEJO
CONCORD
LODI
SAN RAFAEL
PITTSBURG
WALNUT CREEK
SAN FRANCISCO
BERKELEY
STOCKTON
OAKLAND
MORAGA
SONORA
HAYWARD
SAN MATEO
ALAMEDA
PALO ALTO
FREMONT
MODESTO
LOS ALTOS
SANTA CLARA
SAN JOSE
TURLOCK
MERCED
SANTA CRUZ
LOS BANOS
WATSONVILLE
HOLLISTER
MADERA
SALINAS
MONTEREY
CARMEL
FRESNO
FOWLER
DINUBA
KING CITY
HANFORD
VISALIA
COALINGA
TULARE
PORTERVILLE
DELANO
PASO ROBLES
SAN LUIS OBISPO
WASCO
BAKERSFIELD
ARROYO GRANDE
TAFT
MOJAVE

According to the provisions of the contract, each hospital will have three separate Physicians-in-Residence sessions (each of three-day duration and each concerned with a different problem). Several hospitals are still to receive scheduled physicians-in-residence. Depending on the particular problem, there were different faculties for each PIR session. The schedule called for visits in May, September, and December. Special problems were determined later because of difficulties encountered during initial planning stages.

Our initial experience indicated certain difficulties arose in this contract because of its relationship to the academic year. This would not occur in an on-going program. Many faculty members were unavailable during the summer months and many community physicians were on vacation and unavailable for PIR sessions during the summer. Community physicians who are not on vacation during the summer are carrying double loads which limit their time and energy. Therefore, planning session delays inevitably occurred which are not now anticipated.

The following map indicates the vast geographic area covered by the Physicians-in-Residence Program, which compounds the problems of isolation, rational use of existing resources, manpower, recruitment and related problems of professional upgrading and continuing education not only for physicians, but for supporting paramedical personnel.

An illustration of the geographic problems is provided by Exeter. Exeter lies about 15 miles east of Highway 99 (the main San Joaquin Valley north-south arterial) and is the gateway to Sequoia National Park. Lindsay, a smaller township, and Porterville, a larger township lie South of it. Between the highway and Exeter is the County seat, Visalia, about the size of the other three towns combined (see map). Visalia is in a rich agricultural area, which has a large rural population including many itinerant farm workers.

The hospital at Exeter is the largest in its area with 74 beds (compared with Lindsay 49, Porterville 42). Visalia has 68 beds in a modernized hospital together with 19 in a small community, former osteopathic, hospital. The three hospitals, Exeter, Lindsay, and Porterville essentially act as a unit centered on Exeter. Local physicians tend to use the hospital within the particular community, but refer patients requiring more complicated therapy or more evaluation to Exeter. The facilities at Visalia are being expanded and will include an intensive care unit. Physicians from Visalia also attended Exeter and some from Exeter attended Visalia. Pathologic services are unified for the four hospital areas and are being merged with Tulare, which has a 98 bed county hospital and a 104 bed district hospital. This occurred as a result of the Physicians-in-Residence session. Since Tulare is at a later stage of development, it eventually can be a referral point for the entire area. At present, Tulare is a separate visiting area in the Physicians-in-Residence Program.

Selection of Instructors

Instructors were selected by the staff of Continuing Education in Health Sciences after consultation with key staff members in the respective areas. Depending on the educational needs determined to be most urgent, faculty were selected because of their competence and experience in the particular problem, an informal assessment of personality factors, and availability. Since the May and September Physicians-in-Residence sessions, several letters and telephone calls to the Dean of the Medical School have expressed enthusiasm and appreciation of the program. The Dean has become personally interested in the program and its potential and wishes to assist in eliciting even broader support for the program from the medical faculty. Key contacts at the various hospitals, together with a list of faculty,are included in Addendum A. Addendum B contains a partial list of faculty and sessions, either held or scheduled.

Programs at Participating Hospitals

Educational programs were planned with the respective staffs of participating institutions, and are described below.

Exeter

This institution was concerned with obstetrics, pulmonary problems, and surgery. The first visit was concerned with how to go about improving obstetrical anesthesiology and obtaining a board qualified obstetrical anesthesiologist. The specific objectives of the first visit were to establish the institution as an obstetrics center for the area; to set up a blood bank (they currently get their blood from Fresno); to improve the surgery areas; obtain a strong administrator; and set up good obstetrical policing procedures. The second visit was concerned with establishing a program toward pulmonary function laboratories; establishment of protocols on how one manages and follows chronic pulmonary patients; problems of the post-operative and post-accident high incidence of pneumonitis, atelectasis, and intubation. Third, problems of pre- and post-operative surgery care from the general practitioner standpoing and to evaluate preoperative status.

After consultation it was decided the program format would consist of lectures, grand rounds, formal lecture presentation to the Medical Society, and small clinical sessions.

Tulare

Tulare's areas of concern were prevention and treatment of cirrhosis and acute alcoholism, vascular insufficiency (cerebral as well as peripheral), and pulmonary diseases. Objectives of the first visit were to improve the vocabulary of the staff physicians. The physicians felt this need to be talked to "on a practical leveland not the esoteric things in medicine." As will be indicated later in this report, the problem of "vocabulary" recurs in areas where the average age of general practitioners is above 50. Some evidence of a physician "generation gap" exists, which in itself creates communications problems. These physicians were concerned with learning more about common forms of hypertension and its treatment, and with methods of treating infections. The County hospital, which is about 50 years old, has a problem in communicating with medically ignorant indigent patients who present long standing chronic illness but who come in thinking they can get a pill or some medicine that will cure them. It was felt that the general level of awareness of the physicians and their relationships with their patients needed improvement. Another problem was to improve case history taking. The second visit attended to improve recruitment to enlarge the house staff; point out indications for more arteriograms; establish possibilities for treatment or arterial disorders; point out the value of angiography. The third visit attended to Chief of Pediatrics and Orthopaedics; automate the laboratories to give a more comprehensive service to the staff; reduce the schism between the practicing physician and the county physician; and improve the handling and treatment of chemotherapy of tumors of the intestine.

It was decided at this institution to have lectures with the lantern slide demonstrations, followed by actual patient presentation. Evening lecture meetings proved to be very productive.

Ukiah

Physicians at this County hospital were concerned about improving simple bacteriology tests and improvement of the laboratory technologists; better communications, particularly on the detail of actual practice; improve deficiencies in technical matters such as arteriograms; and establish some method of dividing cases between the two competing hospitals. The program at Ukiah consisted of lectures, clinical pathology conferences, and case presentations. The local physicians prepared their cases well and this was followed by discussion of the case with the visiting physician with a question and answer period. Informal discussions of other related medical problems as well as problems relating to medical education were held over dinner at physician's homes.

Watsonville

This hospital was most concerned with developing a program which would not only allow physicians from teaching institutions to come to them, but would also allow them to participate (on an individual basis) at one or more of the teaching institutions in the Bay Area. The first session consisted of a discussion on infectious diseases, the methods of diagnosis and treatment of viruses--in the hospital and out of the hospital. They also are concerned with a general review of the practical core material of recent method of diagnosis and treatment. Also, help is needed with libraries, -- either with organization of a library or association with other institutional libraries.

Chico

This institution was most concerned with establishing a good coronary care unit. The session in September consisted of short lectures, demonstrations of equipment for a coronary care unit, presentation of cases, bedside rounds, x-ray conferences, grand rounds at the County Hospital in Oroville and a formal lecture to the County Medical Society.

Second concern was with common endocrine-metabolic diseases and their management. The program objectives were better referals by practitioners to a specialist in a certain field; proper discrimination in the selection of drugs for management of diabetes and obesity-particularly the hazards of multi-colored "rainbow pills" for the shot-gun treatment of obesity; improved library facilities; improved clinical care through the approval of a general practice residency training program; establishment of a centralized "intensive care unit" at one hospital in order to provide maximum efficiency with their limited resources. This institution chose to conduct sessions for the nursing staff, and two other hospitals in the area (Willows and Oroville), consisting of ward rounds, grand rounds, formal lectures before the County Medical Society, and case presentations.

Redding

This hospital felt a critical need to improve pediatric services. There are only two pediatricians serving the entire Shasta County area, neither of whom use Memorial Hospital. One of the major purposes was the development and dissemination of a protocol on detection and management of Rh problems. Gastrointestional disorders were discussed on the second visit. Memorial is planning to build a new intensive care unit, so the third visit was concerned with the physical organization, equipment that is essential on a daily basis. There is a need for a qualified chest internist and cardiologist in the hospital and in the community. Also, a need for more trained nurses for the intensive care unit and the management of the critically ill patients. The program consisted of informal lectures, breakfast meetings, evening meetings with general and medical staff, ward rounds, and lectures to the Medical Society.

Marysville

This hospital felt the need to have an organized format for general practitioners. One significant problem is the development of rapport between the hospital's physicians and other physicians in the community. This problem relates to better use of regional resources. The possibility of phasing out Yuba General Hospital was discussed (most of the physicians in the area use one of the hospitals there). The first session was developed to mental health and drug abuse. The program consisted of lectures in hospital psychiatry, the team approach to mental health problems, community psychiatry, problems of drug abuse--mariajuana, LSD, amphetamines, methods of effective drug therapy. Community physicians were interested in establishing a mental health clinic in the area.

During the second session arthritis and renal stones were discussed. This program consisted of lectures to the lay community, nurses, ward rounds, and grand rounds at four other hospitals in the area. The third session involved the training in the intensive care and coronary care units, and consisted of grand rounds, formal and informal lectures.

San Luis Obispo

This hospital felt a need for subjects that would have a common interest to all. Their principal areas of need are antibiotics, cardiac resuscitation, and coronary care (they feel a unit needs to be established in San Luis Obispo). The first session consisted of lectures, informal discussions, and ward rounds. The second and third visits have not been made at this writing.

Salinas

This hospital felt a definite need for more paramedical personnel and programs on chemo-surgery and drug injections. The first session consisted of ward rounds, demonstrations of plastic surgery, techniques, surgery and lectures. Salinas General was thinking of extending their intensive care unit to the geographically adjacent coronary care unit, so the second session consisted of lecture, demonstrations, and case presentations regarding the establishment of an intensive care unit.

Merced

This institution felt a definite need in the areas of cardiac resuscitation, pacemaker applications, renal hypertension, and lipid metabolism. The format of the first visit consisted of lectures, ward rounds at two hospitals, and patient presentations. Most of the meetings were scheduled around meals--breakfast meetings, luncheons, and dinners, so as not to take the physicians away from their practice. The second and third visit have not been made at this writing.

Modesto

This hospital felt their physicians needed an up-to-date vocabulary (as noted previously, this problem recurs and requires some research and development of teaching methodologies) and the ability to attract a good house staff. They wanted to establish a strong internship and residency program and were particularly interested in problems of internal medicine and endocrinology. The first session consisted of formal lectures, TB ward rounds, case presentations on retroperitoneal fibrosis, endocrinology problems (adrenal and pituitary), chest clinic, and informal discussions. The second program had a much narrower field of appeal. This program was particularly beneficial to the house staff in their approach to the so-called "crock" with psychosomatic manifestations. The program consisted of lectures on community health centers, the use and abuse of tranquilizers, consultations in child psychiatry and with local practitioners, discussion of hypnosis in general practice, group therapy, and individual interviews. All five hospitals in the community are in competition with each other, and each has a small coronary care and/or intensive care unit. To maintain such a unit with a small number of beds is extremely inefficient and uneconomical. Each unit has difficulty keeping an adequate nursing staff and each unit must duplicate the expensive electronic and resuscitation equipment necessary. To significantly improve patient care and decrease patient costs, the third visitor suggested that one hospital in the community provide the service of coronary care/intensive care with a well-equipped, well-staffed unit, which would have a more stable patient census and nurse-patient ratio. (As will be indicated later, we are getting an overview of how inter-institutional cooperative arrangements can improve services in the various regions since different institutions have differences, strengths, and resources).

Stockton

This institution wishes to establish a strong continuing education program within the community, with a strong focus on the community hospital and its own teaching program. The pathological presentations that are held every Saturday morning appear to be the logical means for the expansion of regular postgraduate training at St. Joseph's in the Stockton area. The first session consisted of bedside teaching, ward rounds, clinical pathology conferences, and lectures. Objectives as a result of the second visit are stronger group relationships among the doctors; more adequate use of latest automated techniques; more extensive use of ancillary health personnel; a more careful review of cases under treatment in the hospital during the course of therapy; and keeping abreast of current literature. The third visit consisted of lectures at two hospitals in the community, case presentations, lecture to the Medical Society. Lectures ranged from the "Treatment of Diabetes and Obesity" to the work on the hirsute woman and problems of osteoporosis.

Reno

This institution was mainly concerned with learning problems in children, pediatric health disorders, recruitment of a pediatric neurologist. (The area has one neurologist whose practice is confined to adults.) Here, again, the problem of an up-to-date vocabulary for physicians was seen as a major problem. The first session consisted of formal lectures, ward rounds and clinical pathology conferences by the visiting pediatric neurologist. The second session by the visiting orthopedist consisted of ward rounds, lecture-seminar sessions, and a lecture to the Medical Society. The third session by the visiting physician was on fluid and electrolyte problems with a broader appeal to the staff than the previous two. This session consisted of grand rounds, clinical department meetings, and surgery meeting in the evening. As in the first and second visits, the program was combined with the County Society and the Surgical Society meetings.

Utilization of Manpower

With regard to the utilization of manpower, it is essential to relate two separate problems in development of medical services:

1. The concept of the patient receiving best possible care within his own community or at least relatively near to it.
2. The availability of personnel.

Concerning the first, while it is clear that very complicated problems in diagnosis and treatment may require a patient to travel to a major regional medical center (Fresno, Sacramento, San Francisco) for a short period of time, his long term management must be within his community. Moreover, the vast majority of clinical problems need to be resolved within a local clinical area with occasional consultation available from smaller regional centers (Tulare, Marysville, Stockton, Eureka, etc.) The evidence is accumulating, as a result of this program, that this objective is not being achieved to the extent that is possible. (See reports of individual residencies.)

There appears to be a shortage of skilled personnel at the regional level with ready availability of the less skilled. Consequently, we find wages for nurses aides as low as $1.65 per hour, while starting Laboratory Technicians receive $1170 per month in Exeter, (San Francisco average $670.) Cooks often replace dieticians, RN's are in short supply, while LVN's are relatively more available and paid less than customarily in major urban areas. All of this reflects on patient care. We must also consider the considerably greater need of flexibility and breadth of skill and understanding by all personnel, but particularly the skilled group, imposed by the wide variation of clinical problems together with limited facilities for their solution.

This applies equally well to physicians themselves. There is a shortage of well-trained specialists in the rural areas, and emergency of specialized services simply are not being provided at the best level in many cases. The young graduate essentially considers the major urban areas first and often is reluctant to move to the secondary urban areas, much less the smaller communities. The problem is compounded by reluctance of critical review in smaller institutions of decisions in practice. "Death and Complication Rounds" are commonplace in large urban centers where judgment of one's peers is taken into account in developing experience. Consultation with one's peers is commonplace and in some situations mandatory (in teaching hospitals), especially those with a highly specialized staff. This does not obtain, in many smaller institutions, to the detriment of patient care and the lowering of general (although not necessarily specific) individual standards. Thus in many situations, there is not only a shortage of physician manpower, but also a failure in the best utilization of what is available.

Returning faculty report frequently that local physicians "lack vocabulary." This indicates that research is needed to develop communication skills among and between physicians, which may require the development of new teaching methodologies utilizing a variety of techniques. Indications are that intensive efforts must be made to build a strong continuing education effort in all these communities, involving not only physicians but paramedical personnel as well.

The Physicians-in-Residence program suggests that manpower projections must be community based and tied to work function and service delivery systems. Evidence indicates that cooperative regional arrangements would maximize health resources and improve patient care. In some instances, one hospital could become the neonatal, pediatric center for an entire area, another could be the center for intensive coronary care, and so on. This has not been done to any appreciable extent.

Training resources for paramedical personnel must be developed through community college, state college and university cooperation.

An unexpected result of the Physicians-in-Residence program is that it provides medical school faculty with the opportunity to observe practice and problems in ways which were not available. This has had a profound effect in arousing faculty to the importance of continuing education and the leadership role a major medical center must assume. The Physicians-in-Residence program provided the first relationship with a teaching facility for many physicians in the areas visited. The opportunity to observe, listen, talk over problems and to ask questions proved to stimulate physician interest. The chance to react and transact with visiting faculty indicates that this technique, could be the nucleus for developing continuing efforts which would make the use of television, correspondence-preceptorship, staff development and technical assistance programs more effective. The Physicians-in-Residence sessions had the effect of opening channels of communication among and between staffs which had been either rudimentary or non-existent.

Special Problems and Recommendations

We have encountered some problems, all of which seems amenable to solution.

1. Initial anxiety, that criticism of practice might result, can be overcome. This is particularly relevant among older physicians who are not regularly in contact with the University and who are not actively engaged in their own continuing education. Consequently, in some communities there was a dearth of case material, particularly on first visits. This seemed to be readily dispelled in each community, and by the last visit, an entirely different attitude appeared to develop.

2. Local responsibility can be effective when a single person sets as liaison, with appropriate designated members of the staffs assigned to prepare the actual material. Under this arrangement, an active program can be more easily achieved, than when primary responsibility is fragmented. Local continuity responsibility therefore seems essential, for a reasonable period of time, to avoid repetition of preliminary groundwork. This is important as a cost factor, since excessive office personnel, travel expenses, and long distance telephone are otherwise necessary.
3. Communications between the Physicians-in-Residence and their local colleagues is essential prior to the program. In certain communities where this was done, the result was a program that was varied and well-oriented to both the community needs; it also considerably eases the task for the Physician-in-Residence.
4. Increased involvement of the local medical societies is necessary, not only to ensure greater interest and possible further development of the program, but to ensure the most active participation by local chairman.
5. In communities where there is more than one institution, there may be wide ranges of cooperation between staffs, as well as feuding and total separation. It seems most desirable, rural areas as well as in certain more urbanized communities, that more than one institution be utilized.
6. The duration of the visit should be two or three days, depending on the needs and desire of local physicians.
7. Advanced scheduling (which is only possible with a long-term arrangement) is more desirable, coinciding with County Medical Society meetings and other local educational functions.

8. Where paramedical personnel were involved, there appeared to be a distinct increase of value in the program to the communities. This is important since in-service training in most hospitals is often still at a rudimentary stage of development.
9. It is essential that the local liaison personnel be given real responsibility, but they should also be energetic, well liked, and respected members of the community. In two communities considerable difficulty in scheduling has resulted from a simple delay at the local level.
10. It is essential that a system be designed to insure that alternate physicians are available in the event of unavoidable cancellations. One visit, for example, was cancelled because of last minute scheduling changes.
11. It seems far better for only one man to go out at a given time. This does, however, produce some stress on certain faculty members because of conflicting responsibilities.
12. It does not seem feasible for such highly specialized areas as Ophthalmology to be represented in this program. However, it is interesting that plastic surgery provided a most successful session, possibly because of the actual practical clinical work accomplished.
13. The most successful visits were accomplished with a variety of methods of presentation. Identification with clinical practice is an important criteria in choosing the Physician-in-Residence. It is important that basic science and current research are discussed with physicians only in the context of their actual clinical needs.

These conclusions are drawn from the interviews, liaison discussions and as a result of the evaluation conference (Appendix C).

II. EVALUATION

A formal evaluation of the PIR program was not conducted, since our major effort was expended toward the design and implementation of this pilot demonstration. However, based on discussions with returning Physicians-in-Residence, direct communication from the participating communities, and on the evaluation conference held in San Francisco, it is clear that many and far reaching changes in community medicine have occurred--especially as these directly affect local patient care. Some of these changes are discussed passim in this report, and particulary in the concluding section. The changes reported probably represent only a very small sample of probable effects attributable to the PIR program. Nevertheless, they do appear to be sufficiently varied and substantive as to suggest the direction in which a documentation of these changes should move. For these reasons, we feel it is appropriate to include the outlines of a formal evaluation plan in this final progress report.

The primary aim of continuing education is the direct and long-range improvement of local patient care. An assessment of this improvement depends, first, on identifying those variables which are directly associated with the quality of community medicine--as a consequence of the community's participation in the PIR program. For each combination of community and medical specialist (42 possible combinations, using the structure of this program as a base), there is some unknown, but denumerable, number of potential changes--variables that could be identified. The number and types of such variables will (and probably should) vary widely among community-specialist combinations. Through interviews with individual Physicians-in-Residence, local hospital administrations, and local continuing education personnel, we can identify the community-specific effects associated with a PIR program. Once identified, quantification of base rates and change parameters can proceed, according to standard and acceptable statistical procedures.

Many changes consequent on the PIR program would be immediate and dramatic. For example, one community cited a reduction of infant morbidity in Rhesus problems. Equally important, longer range effects would also be manifested, which would eventually have great impact on local patient care. Her we can cite progress by one community in the acquisition of improved coronary care unit, through the modification of existing facilities. In addition, ordinary probability, reinforced by statements made at the final evaluation conference, leads us to anticipate that changes would be widespread and not exclusively community-specific. These would include attitudinal changes toward continuing education itself, increased cohesiveness of local medical communities, and, enthusiasm for locally directed and financed programs in continuing education. Although present data is incomplete, it nonetheless tends to support these probabilities. With this as a background, the remainder of this section contains an outline of procedures for a required evaluation.

Evaluation Procedure

1. Variable to be Evaluated
   a. All variables identified through interviews with participating physicians, hospital administrators, and local continuing education personnel.
   b. Attitudes of local physicians toward a variety of effects associated with the PIR program, e.g., preferences among various methods of continuing education, increased effectiveness of these methods as a result of PIR.

c. Subjective ratings of PIR, e.g., increased community cohesiveness, increased cooperation within and between communities.

d. Local attendance at PIR sessions.

e. Increased attendance at other courses in continuing education.

f. Increased use of local and university library facilities.

g. Changes in referral practices, within a local community and outside to major medical centers, e.g., in cases of difficult gall bladder symptomology, criteria for referral can be established, prior to surgery; likewise, in the event of post-op thoracic complications, creditable and useful protocols could be instituted, whereby an anesthesiologist is consulted to assist local, attending physicians.

The above are some of the areas in which, hard quantifiable data could be gathered. And this data could be characterized by the rational presumption that it is at least associated with, if not consequent upon, a local PIR program. However, there are other specific instances in which quantifiable data could be acquired and reduced. These instances could include: alterations in periods of hospital stay; changed rates of morbidity, mortality and autopsy; as a consequence of modified criteria for surgery, the statistics of elective surgery might be altered (e.g. hysterectomies); and, a well established PIR program would undoubtedly include an increased use and clinical implementation of modern laboratory testing procedures. These could involve, for example, more disease-specific criteria for the selection and instution of such tests (e.g., diabetes, accompanied by vascular and neurological complications). Two final points should be mentioned in connection with quantification: (1) hard statistical data is essential to an accurate evaluation of a PIR program, but, (2) this data will not likely have its fullest possible impact unless it is gathered and interpreted in the context of a comprehensive evaluation plan, whose methodology and approach take into account the needs and desires of local medicine.

Community hospitals in cooperation with our evaluation staff would design a questionnaire, to be distributed by local hospitals, whose purpose would be to elicit personal and professional data, as well as attitudinal responses to the categories cited above. Objective records (hospital, supply, attendance, etc.) would also be tabulated and analyzed by the evaluation staff. Computational facilities are available for this purpose.

2. Data Analysis

The majority of the quantitative data would be collected in the form of increased and decreased Frequency Response. For example, in one case we may have a decrease in morbidity as a consequence of a new technique, and elsewhere, there might be an increased frequency in the diagnosis of various diseases--as a result of improved protocols. Such frequency changes can be tested statistically with standard indices, such as x^2 and Fisher's exact binomial test.

For those variables not directly quantifiable, we would use subjective impressions of returning physicians. In this category, indirect quantitative methods can be used to rate such variables as community cohesiveness, cooperation, etc. Numbers can then be assigned to the rating categories and pooled estimates obtained across community lines.

Finally, a Scaling of physicians' attitudes toward different methods of continuing education could be obtained by the use of Pair-Comparisons and Thurstonian analysis. Physicians would indicate a preference between all possible pair-combinations of continuing education methods, e.g., radio vs. lecture, PIR vs. television, etc. These orderings could then be transformed into an interval scale, which reflects the degree of preference of continuing education methods.

This schema does not purport to be more than a skeletal explanation and outline of the fundamental approach that could be used. However, in our judgment it represents a sound approach to a realistic and useful evaluation of future PIR programs. Finally, since no methodology is better than its data sources, it is worth mentioning that we have every reason for believing that local physicians and health personnel would cooperate in the execution and completion of such a plan of evaluation.

III. ACCOMPLISHMENT OF GOALS

Almost the entire cycle of three Physicians-in-Residence has been conducted in fourteen community hospitals varying from medium size urban centers to small agriculture areas. Reports are now on file by three different members of the University staff in relationship to their specialities concerning the problems and potentials they uncovered during their visit. (See Appendicies A and B)

A conference was held in which reports from all except one of the participating hospitals were discussed by a group including the visiting physicians-in-residence, representatives from the community hospitals, and representatives of the Continuing Education staff. From this conference, it became clear that there is unanimous approval of this demonstration project by local community physicians and enthusiasm for the project by the faculty at the Medical Center. (See Appendix C)

Depending upon the speciality, the nature of the particular hospital, the number of contiguous hospitals, and the distribution of physicians by specialities and general practice, it was felt two or three day sessions were needed; however, a substantial number of physicians felt that three day sessions were preferable.

It was unanimously expressed at the Evaluation Conference that it is too early, without further investigation, to measure the full effects of the program. It was also generally believed that any given program format would have to be designed in compliance with local needs and desires.

There was general expression that further visits with greater prior contact with the community physicians were essential, and that the kind of program would vary with the nature of the medical community involved. Some expressed a desire for more lectures and slides followed by discussion. Others preferred small group contacts and more ward rounds.

It was felt that the return of the original Physician-in Residence for a period of a day to discuss again some of the problems was desirable, but at least two other Physicians-in-Residence either from other fields or representing another point of view within the same field should be included in year II.

It was clear from the discussions that there was a definite "halo" effect upon the whole medical community including the trustees of hospitals, allied health professionals, etc. If this is the case, it should result in greater cohesiveness of the medical community, providing that initial efforts can be sustained and reinforced.

As a result of the Evaluation Conferences and of communications from the local continuing education coordinator and our physicians-in-residence, certain changes in the practice of medicine have been communicated to us. Since these are only beginnings, exact figures are not available because (a) sufficient time has not elapsed to gather statistical data and (b) the material had not been collected for statistical evaluation. (It must be pointed out that in the initial contact with the hospitals, evaluation was under-stressed because it was felt that potential hostility on the part of community physicians should be avoided. As the project became well under way, it became clear that the local community would aid in evaluating their own performance). There had been some fear among older practitioners that they would be criticized by members of the University staff. These fears have been largely dispelled. Local physicians accept desirability of evaluation in cooperation with us.

As a result of the Year I experience, the following has occurred:

1. In Tulare County, equipment has been ordered for pulmonary function screening and new protocols for post-operative care from the pulmonary point of view and the care of pulmonary problems in accident cases is well under way.

2. In Marysville, a different policy in the management of abdominal adhesions appears to have been well accepted, although it is too recent to see what will occur over the long term. Should this trend continue a reduction of admissions following abdominal surgery for the second time should result.

3. In Redding, there has been a reduction of infant morbidity in Rhesus problems since the first visit in May, 1968. Three cases were treated entirely differently and a general protocol of management is now widely available throughout the area. The success of the first visit was so great that the hospital requested us to select another pediatrician to visit Redding -- at their own expense. (See Appendix C)

4. In Exeter, a reduction in the number of hysterectomies and more careful prior screening appears to have been adopted. Also, the autopsy rate appears to have been increasing, and, more important, physicians are attending the autopsies of their own patients.

5. In Merced, a washout technique of IVP's is being used, which had not been heard of before. Also, they performed their first renal biopsies.

Several communities commented that they are adopting pre-surgical screening procedures to a greater extent.

CONCLUSIONS

It seems clear to us that some considerable impact is occurring as a result of the first year's experience. However, the factor of novelty must be carefully considered and at least a second year is needed to ensure that this was not the criterion of success.

It appears that some real changes, which can be objectively measured, are in the process of occurring, but their full implementation requires more time than the $10\frac{1}{2}$ months of the original contract.

The strong impression by the communities themselves that they need more of this program, and in some cases a greater intensity of it is encouraging. The development of this program has not yet reached the stage where it could become self-supporting. However, in Tulare County they have proposed to the University to expand the Physicians-in-Residence Program throughout the County. Redding brought in another one day Physician-in-Residence at its own expense. All communities have expressed a willingness to explore their own funding, although some pointed out that they would only be able to partly fund such an effort of the scope of the Physicians-in-Residence Program.

We are at a critical stage in this demonstration project. A tight evaluation design is essential for ultimate success in judging the effectiveness of the Physicians-in-Residence Program. Certain aspects of evaluation appear to present hard factual data. This would include the opening of intensive care units, changes in procedures, new testing techniques, reduction in morbidity or mortality of patients, change in hospital bed stay and duration of stay, more immediacy and appropriateness in specific investigation and treatment, as well as such matters as proposed modification of the hospital.

It is clear already that there is a trend toward these changes at this time, although the program is still too recent for data to be readily available. (Some of the Physicians-in-Residence of the first cycle have only just returned.)

More difficult to analyze is attitudinal change within the community. Certain data may be obtainable, such as pooling of facilities for greater economy, the development of new in-service consultative groups within the community, changes in referral practice within the community and, to outsiders, increased use of library facilities afforded by the University of California and other institutions, and the development of parallel programs by themselves. Very important is the development of an on-going local community group accepted within the community with a responsibility for continuing education. Although attendance at programs is not by itself a significant evaluation criterion, it will be of great interest and importance to see if any trend develops toward greater participation by the community in this program as well as others. There are circuit riding courses sponsored by the California Medical Association which have been completely static in physician attendance. There are certain hospitals where evening lecture series are conducted by the University of California, with a small but sufficient attendance, but again quite static. The development of any continued relationships between the local community and the physicians-in-residence would be another important area of attitudinal change. Changes in the acceptance of other continuing education programs during the following year would obviously be worth considering.

We hope to develop cost factors in relationship to cost of such a program, savings potentials as a result of improved community medicine, and potential savings in closer integration of facilities within the community. It is our impression that on the basis of partial, but encouraging early evidence, a demonstration project with significant evaluation can be achieved by continuing the project, with modifications as suggested above, arising from our experience of the first year.

Finally, the relationship between P-I-R and our total health sciences programming should be discussed, as called for in the prescribed areas of this report. There are essentially two features to be noted: (1) ways in which this new approach extends the effectiveness of continuing education (hence, improved patient care), and, (2) limitations of a P-I-R approach, which require augmentation by proven, traditional methods of continuing education.

Under increased effectiveness through P-I-R we have observed such factors as the following: physicians attend local visits in proportionate numbers which exceed typical gatherings at courses away from home; P-I-R considerably increased contact and involvement with local hospital administrations; responses to local programs were generally more intense than for most medical radio and television programs; P-I-R could, and did, focus on precise, specific clinical problems at hand; and, intra-community organizational problems were openly aired and often resolved.

However, even with these distinct advantages, a P-I-R approach is not an exclusive and definitive solution to the problem of maintaining effective continuing education. Short-term and highly localized programs cannot satisfy the need for: courses which are carefully planned far in advance and can thus schedule organized multi-disciplinary presentations; designers of courses can draw upon long experience of effective (or undesirable) topics; courses intensively surveying specific areas of medicine and clinical science; courses given under the auspices of a major teaching center can offer a variety of practical in-service programs at associated hospitals, e.g., pediatrics, learning disorders, ENT, etc.; while the immediacy of local programs is obviously desirable, latter do not offer necessary detachment from local clinical loads, which study and discussion away from home can do --- particularly study without the press of intervention; and, finally, isolated or very small communities cannot easily be included in a P-I-R approach, except at disproportionately great expense. Under these conditions, a combination of medical radio or television, and time off for courses at major teaching centers, offers the best solution to a difficult problem.

In conclusion, the P-I-R approach has clearly demonstrated its validity and effectiveness ---in the context of a sustained and comprehensive approach to continuing education in the health sciences.

ADDENDUM A

LIST OF HOSPITAL KEY CONTACTS AND FACULTY

	Contacts	Faculty
Exeter	Dr. Ward Evans Chief of Staff	Dr. Harold Lyons (Ob-Gyn) Children's Hospital, San Francisco
		Dr. Roger H. L. Wilson (Pulmonary) UC Faculty
		Dr. William F. Blaisdell (Surgery) UC Faculty
Tulare	Dr. Eugene Bifulco Medical Director	Dr. Gennaro M. Tisi (Cardiovascular) UC Faculty
		Dr. Edwin J. Wylie (Surgery) UC Faculty
		Dr. John V. Carbone (Medicine)
Ukiah	Dr. Frank H. Dailey President County Medical Society	Dr. John R. Gamble (Gastroent.) UC Faculty
		Dr. Frank H. Leeds (Vasc. Surg.) UC Faculty
Chico	Dr. Carlton Huitt Chairman Program Committee	Dr. Harold I. Griffeath (Cardio.) UC Faculty & Director, Coronary Care Unit Children's Hospital, San Francisco
		Dr. John H. Karam (Med.-Metabolic) UC Faculty
Redding	Mr. Robert A. Roberts Administrator	Dr. Jan Alban (Pediatrics) UC Faculty
		Dr. Richard G. Devereaux (Gastro.) UC Faculty
		Dr. Stuart C. Cullen (Anesthesia) UC Faculty
		Dr. Joseph Lee (Anesthesia) UC Faculty
Marysville	Dr. Joseph Salopek Chief of Staff	Dr. Kay H. Blacker (Psychiatry) UC Faculty
		Dr. Hibbard E. Williams (Endocrin.) UC Faculty
		Dr. Leon Goldman (Surgery) UC Faculty

Salinas	Dr. Carl J. Leonard Medical Director	Dr. Mar W. McGregor(Plastic Surgery) St. Francis Hospital San Francisco
		Dr. Raphael B. Reider(Cardio.) UC Faculty
Merced	Dr. John MacCarthy Chairman, Program Committee	Dr. Alan J. Coleman (Urology) UC Faculty
Modesto	Dr. William A. Todd Director, Medical Education	Dr. Vincent C. DiRaimondo (Endocrin.) UC Faculty
		Dr. Kay H. Blacker (Psychiatry) UC Faculty
		Dr. Morley M. Singer (Anesthesia) UC Faculty
Watsonville	Dr. David Bushman Director Medical Education	Dr. Richard Leonards (Pediatrics) UC Faculty
		Dr. Moses Grossman (Pediatrics) UC Faculty
San Luis Obispo	Dr. Richard L. Anderegg Director, Medical Services County Hospital System	Dr. Kenneth L. Melmon (Pharmacology) UC Faculty
Stockton	Dr. David Bernard Director County Education Committee	Dr. Lloyd H. Smith, Jr. (Medicine) UC Faculty
		Dr. Victor Richards (Surgery) Chief of Surgery Children's Hospital, San Francisco
		Dr. Charles T. Carman (Medicine) UC Faculty
		Dr. Peter H. Forsham (Med.-Metabolic) UC Faculty
Reno	Dr. Robert J. Barnet Chairman, Continuing Education Committee	Dr. William Murray (Orthopedics) UC Faculty
		Dr. Douglas L. Crowther (Peds.Neuro.) UC Faculty
		Dr. Gary Kardos (Med.- Renal) UC Faculty

Eureka did not participate because of scheduling problems.

ADDENDUM B

PHYSICIANS-IN-RESIDENCE

HOSPITAL	PIR	DATE
Enloe Memorial, Chico	Harold I. Griffeath, M.D.	October 29-31, 1968
	John H. Karam, M.D.	January 21-23, 1969
	Alexander Anylan, M.D.	April 8-10, 1969
General Hospital, Eureka	Melvin M. Scheinman, M.D.	March 7-9, 1969
Memorial Hospital, Exeter	Harold M. Lyons, M.D.	May 13-15, 1968
	Roger H. L. Wilson, M.D.	September 16-18, 1968
	William F. Blaisdell, M.D.	December 9-11, 1968
Yuba General, Marysville	Kay H. Blacker, M.D.	May 21-23, 1968
	Hibbard E. Williams, M.D.	October 23-25, 1968
	Leon Goldman, M.D.	January 23-25, 1969
Merced General, Merced	Alan J. Coleman, M.D.	October 23-25, 1968
	Edward H. Strisower, M.D.	March 26-28, 1969
Scenic General, Modesto	Vincent C. DiRaimondo, M.D.	May 13-15, 1968
	Kay H. Blacker, M.D.	December 10-12, 1968
	Morley M. Singer, M.D.	January 7-9, 1969
Memorial Hospital, Redding	Jan Alban, M.D.	May 22-24, 1968
	Richard G. Devereaux, M.D.	September 25-27, 1968
	Stuart C. Cullen, M.D.	January 14, 1969
	Joseph Lee, M.D.	January 15-16, 1969
Washoe Medical Center, Reno	Douglas L. Crowther, M.D.	June 12-14, 1968
	William R. Murray, M.D.	September 25-27, 1968
	Gary Kardos[illegible], M.D.	January 8-10, 1969
General Hospital, Salinas	Mar W. McGregor, M.D.	May 22-24, 1968
	Raphael B. Reider, M.D.	September 26-28, 1968
	Michael Thaler, M.D.	February 26-28, 1969
County General, San Luis Obispo	Kenneth L. Melmon, M.D.	December 5-7, 1968
St. Joseph's, Stockton	Charles T. Carman, M.D.	May 16, 1968
	Lloyd H. Smith, Jr., M.D.	May 17-18, 1968
	Victor Richards, M.D.	September 19-21, 1968
	Peter H. Forsham, M.D.	December 18-20, 1968
County General, Tulare	Gennaro M. Tisi, M.D.	May 20-22, 1968
	Edwin J. Wylie, M.D.	September 3-5, 1968
	John V. Carbone, M.D.	January 13-15, 1969

Mendocino County, Ukiah	John R. Gamble, M.D.	May 22-24, 1968
	Frank H. Leeds, M.D.	October 2-4, 1968
Watsonville Community, Watsonville	Richard Leonards, M.D.	December 12-13, 1968
	Moses Grossman, M.D.	December 14, 1968
	Martin Brotman, M.D.	March 25-27, 1969

Report on PHYSICIANS-IN-RESIDENCE Program
Memorial Hospital, Redding
May 22-24, 1968
Dr. Jan Alban

CONFIDENTIAL

Dr. Kimbrough: Dr. Alban, you went to Redding Memorial Hospital. I would like to know the strength and the weaknesses of the following: the level of practice---what are the strengths and weaknesses of the level of practice in Redding, California?

Dr. Alban: The strength of the hospital, I think, is primarily based on the physicians that are members of the staff of the hospital. I found them to be an extremely intelligent group, a very receptive group of physicians. I believe I met a greater majority of them at the meetings, and their questioning of my topics indicated that they were quite well versed in the field of pediatrics. Now, of course, it's hard for me to determine the level of practice in surgery or internal medicine, but from my brief contact with the physicians in the other fields, I think they can compare very strongly with the people that we have here in San Francisco---the better group of physicians.

Dr. Kimbrough: Did you notice any weaknesses as to the level of practice?

Dr. Alban: As to the hospital, I don't think there were any weaknesses in the hospital.

Dr. Kimbrough: I mean, they are without pediatricians.

Dr. Alban: They do have two pediatricians in Redding. Both pediatricians, apparently do not use the Memorial Hospital, they use the hospital across the way. I understand that both pediatricians have been there for quite a while. One pediatrician happened to be the Doctor Stanford I've known from my days of medical school, who apparently practices pediatrics as a solo practice, and they certainly could use another pediatrician, or two even three in that area.

Dr. Kimbrough: So there is a need for, in your judgment, for pediatrics?

Dr. Alban: Oh definitely, very definitely, they do not have a good set up there for pediatrics, per se but then, fortunately, why would they have one if they don't have a pediatrician. I'm sure that they would bend backwards to do everything if somebody went there to practice pediatrics.

Dr. Kimbrough: Did you notice any areas where there could be some improvement from a clinical point of view?

Dr. Alban: The hospital is strictly a private hospital with no clinic facilities. I didn't see any clinic facilities, since the patients are all private patients. In reviewing some of the charts, I think that in general that this is a very well run private, little hospital in a small town.

Dr. Kimbrough: Did you find any weaknesses in the charts?

Dr. Alban: None that I could see.

Dr. Kimbrough: What about the areas where you think that possibly the hospital could be improved, administratively?

Dr. Alban: I doubt it. I think it's very adequate, they've got a fine administrator, a gentleman, and a very intelligent person who is very well liked apparently by the entire house staff.

Dr. Kimbrough: What about the major problems in the community itself from the medical point of view?

Dr. Alban: From the medical point of view, I think the greatest problem they have is their pediatrics. From the little I've heard about the pediatricians in the area, there's a great deal left to be desired from the pediatricians in the sense that they---I hope that this, of course, is confidential material---but what I understand there is a great deal of antagonism between one of the pediatricians and Redding Memorial because of his unavailability to the general practitioners in the area. The second pediatrician is available but he must be so swamped that he can't do everything else. One pediatrician makes very few house calls and is very unavailable, whereas the other rather gets the brunt of it. I think they've got a tremendous lack as far as pediatric care is concerned, for their community. Considering that Redding is the hub for the northern district of California, the Shasta district, that leaves a lot to be desired.

Dr. Kimbrough: Any other problem outside of that? Well, of course, with you being a pediatrician I don't suppose you'd know---

Dr. Alban: I could not detect any other problem. I think that most of the people that I've met speak highly of their surgeons, highly of their internist, and highly of their general practitioners.

Dr. Kimbrough: What is the use of ancillary services in this hospital?

Dr. Alban: For instance?

Dr. Kimbrough: Well, your . . . they have a cobalt machine.

Dr. Alban: They have a pretty well set up ancillary services I'm sure. I was not able to see their rehabilitation services, but I understand their laboratory facilities, their x-ray and cobalt facilities are good. They've got a good pathologist and they have a radiologist who comes to the hospital for the community. I believe they did install a cobalt unit which they hope to put in use sometime this year. I don't know if it's in use at the present time.

Dr. Kimbrough: What about the potential of referral of the patients from there to the major medical centers?

Dr. Alban: I think the potential is great there. I'm sure it is used because they've been more than inquisitive about the idea of referring problems to the University, or to the outlying specialist in San Francisco, Sacramento and areas where they felt the facilities might be available to them.

Dr. Kimbrough: Do you have any suggestions for improving all the things that we have mentioned?

Dr. Alban: I think the most important improvement that has to come in that hospital is in pediatrics. I think in a community as large as Redding it is a crime to have only two pediatricians serving the entire Shasta County area. Especially with as much antagonistic conversation that went on about one of the pediatricians. I feel that they need help. They need pediatric help in the area. Whether they need help in internal medicine, or in surgery, remains to be discussed by someone else who may be going into that area, but from what I could gather from my discussions with Mr. Roberts, the Administrator, their need in Pediatrics is phenominal. It's very critical.

Dr. Kimbrough: We've gotten the two very interesting, very nice letters appraising you. Saying that you are an outstanding "ambassador", and that they'd love to have you back sometime. If you were to evaluate or estimate your trip would you say it was a success?

Dr. Alban: I think it was very successful. I don't know whether I hit the subjects that were most interesting to them, but the sessions that were supposed to last an hour and a half, lasted four and five hours. I think it did show that people there were extremely anxious to learn the material, and as far as I'm concerned, if they would like me to come back, I would be more than happy to go back to discuss some other problems.

Dr. Kimbrough: Do you have any other final comments that you would like to make? This is a report that will be sent back to Washington.

Dr. Alban: The comment that I have to make is that this is a fine community with fine physicians, and that it is a very well run hospital which has plans for expanding. But they need help in the field of pediatrics and I think that this is a very crucial point in the entire medical practice of that area.

Dr. Kimbrough: Would you like to go back again?

Dr. Alban: Yes, I would.

REPORT ON PHYSICIANS-IN-RESIDENCE PROGRAM

SCENIC GENERAL HOSPITAL, MODESTO
December 9-11, 1968
Dr. Kay Blacker

CONFIDENTIAL

The level of practice in psychiatry in this Community hospital is almost none. At this point, there's not a psychiatric unit in the hospital. The residents have not been particularly interested in psychiatry or in the psychological aspects of their patient's illness. The only time this would have come up in the resident's mind would be in terms of differential diagnosis or in regards to a patient that they thought was a crock. The patients who have needed hospitalization have been referred to Modesto State Hospital, which is right in Modesto. The level of care at Modesto State Hospital has been quite limited They have at most only one or two trained psychiatrists on the staff; most of the patients are cared for by general physicians who have been working there at the hospital.

Areas of potential improvement. The County that Modesto is in is Stanislaus County. That County has really not pursued any kind of reasonably organized plans for the changes that are about to take place both in terms of the commitment of psychiatric patients and in terms of the funding. What I mean by this, as of July 1, 1969, the only reason for which an individual may be held against their will is if the individual is a danger to themselves or to others. This is a change that has taken place in the laws as a result of the Latterman-Petris Short Bill. What this will mean is that somebody can say to a judge or somebodys lawyer can say to a judge, that I'm crazy but I don't hurt myself and I don't hurt anyone else and I really don't want to spend any time in a hospital. I'd much rather get treated at home. They cannot commit him to the hospital, the way the law is written at the present time. This has not been grasped by either the State hospital people in Modesto or by the General medical group, with possibly one exception, that is the group down in Turlock, which is building Emanuel Hospital. They have funding and they're moving towards construction of the community mental health center. The other part has to do with the funding. As of July 1, 1969, the State will pay 90% of care for psychiatric hospital patients, and the County will pay 10% of the care. This funding will take place regardless of where the patient is treated. Whether the patient is treated in a State hospital or a local hospital. Which means there will be no financial advantage for the Counties to ship people off to the State hospitals. All of what I'm saying has not been grasped or has not been worked on by Stanislaus County.

I'm told that in Modesto itself, there are some four or five relatively small private hospitals with another one building. This is a result of various vested interests, with nobody wanting to give up anything. The medical community is split at least down the middle if not in more ways than two. From what I learned, the residency training program in Modesto State hospital has suffered as a result of the Medical Bill. A lot of patients now going to private hospitals. What will happen over the long run to Scenic General Hospital, which is the County hospital, is under discussion and debate at the present time. The State Hospital in Modesto is an isolated entity into itself. It has very little interaction with the medical group in the community, at least not psychiatrically. There are consulting people from the medical group who come in and work with other kinds of problems; surgical and medical problems. There's very little interchange psychiatrically in the community. The Modesto State hospital is interested of course in its own life, that is, it's interested in staying alive. The $7,000,000 payroll, there are politicians interested in its staying alive. As far as I know, there's been no regional kind of planning for the development of a County-wide mental health system which would essentially determine what role the State Hospital would play, or what role community clinics would play. This has not been happening. One of the things that has been discussed is that they may put ten or twelve psychiatric beds into the General Hospital. This is a general hospital that may or may not continue to develop. They may or may not exist in four or five years depending on what happens in relationship to medicine in the community. Obviously a lot of planning is going to be needed there. The Medical Center here could be most helpful in organizing some of the planning. Nobody's talking to anybody. I got a chance to be with four or five of these groups. The State Hospital group isn't talking to the General hospital group in terms of what the long range plans are. The County Supervisors have not begun to organize any kind of a County-wide program. There's a kind of a one-horse, Short-Doyle program in the city. That is one psychiatrist and a social worker. Apparently this is not thought of too highly by the general medical community and of course has only been able to function very minimumly with such staffing. Where this would go and why it's not part of either the County hospital or the State hospital is another question. The State hospital there is a hospital that the State bought from the Army at the close of World War II. It's a barracks kind of thing. It's obviously been a backward kind of State hospital, because one of the reasons they have trouble getting staff out there. At some time in the future, they're going to have to decide what to do out there. They're going to have to build a new facility. The State Department of Mental Hygiene plus the County people should evolve a coordinated and workable plan. The residents seemed to respond to the things I had to say, and I had a good time with them, and they had a good time with me. The lack of oral planning in psychiatry is rather noticeable.

They kept me busy from the time I arrived until the time I left. I saw four or five patients. There were breakfast meetings at Scenic General Hospital. There were lunch meetings and there were meetings at 8:00 at night. I saw a lot of the residents. There were a limited number of physicians in attendance at these various things. One morning we were talking about child psychiatry; there may have been six or eight pediatricians, and we talked about a case. There may have been ten or twelve maybe fifteen physicians from the community in at various aspects of these conferences. One evening when we talked about groups, there were seven social workers from the schools who were working with groups who came. There is a psychiatrist there by the name of Dr. Soling, who was trained two years in Nebraska and a year at Mt. Zion here, and now does primarily group work. He seems to be a fairly knowledgeable and reasonable kind of guy and I think would be a resource to use. That was the only psychiatrist that I met, and he came and took part in various discussions. I think he's a useful resource in the community there.

I saw three patients that I interviewed and discussed in a rounds-like situation for the residents. They refer to Modesto State for psychiatric hospitalization. Modesto State will occasionally refer to Langley Porter. My recommendation is that we let them know about this lack of planning in a tackful way, and have some people from here to help them begin to organize. The people that should be talked to are obviously the people at Modesto State Hospital, which would include the administrator very definitely. I don't know if I saw the administrator. I saw somebody out there that may have been the educational director. I saw four patients out there in the teaching conference; two of which were probably misdiagnosed and possibly mishandled.

Who needs to be talked to. .. the people from Modesto State Hospital, that would be the administrator there and also this should involve people from the Department of Mental Hygiene in Sacramento. The County Board of Supervisors needs to be talked to, and whoever runs Scenic General Hospital; that is not only the administrator but the Board of Supervisors. This program that is developing down in Turlock is the one that shows the most promise and the most know-how. There is a population approaching 200,000 in that county. You could run two mental health centers. The Short-Doyle clinic should be part of the State hospital. Some plans should be drawn up for these things for the next few years. Maybe the community psychiatry people here at Langley Porter, would be the ones to do this. This is what needs to be done as far as psychiatry. I'm talking now more in terms of community mental health and treatment of patients and organization.

UNIVERSITY OF CALIFORNIA
SAN FRANCISCO MEDICAL CENTER

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO
100 YEARS 1868 1968
A Tribute to the People of California
SANTA BARBARA • SANTA CRUZ

SCHOOL OF MEDICINE

Please address reply to the undersigned at
UNIVERSITY OF CALIFORNIA SERVICE
SAN FRANCISCO GENERAL HOSPITAL
SAN FRANCISCO, CALIFORNIA 94110

February 14, 1969

L. S. Kimbrough, M.D.
Project Officer
Continuing Education in Health Sciences
University of California
San Francisco Medical Center

Dear Doctor Kimbrough:

This is in response to your request for information about the Physicians-In-Residence Program.

1. The level of practice in the community hospital in Exeter was relatively good. There were several excellent specialists practicing good quality care, however, the level was variable and, in my opinion, general practitioners were doing surgery above their level of competence.

2. The weaknesses, as far as practice is concerned, are that the community is far removed from major educational centers. Many of the doctors in the community were probably not participating in postgraduate programs and are not current in medical practice. It was undoubtedly these members of the staff who did not attend the lectures. Roughly tow out of three members of the Exeter Hospital staff were in attendance and these were the same ones on the three days that I was there.

3. The strengths, as far as practice is concerned, consisted of family practice and a close relationship between the patient and his physician.

4. One area of potential improvement is the need for postgraduate education on a continuous basis. I concur in the thought that the program as outlined has an excellent chance of answering the requirement in that it brings education to the physician who is too busy to participate in programs at far-removed centers of learning.

5. Medical care in the hospital might be improved by increasing the number of specialists that practice in the area and by requiring postgraduate education for staff privileges.

6. The problem areas in the community itself--none recognized.

7. Use of ancillary services. Good.

8. Referral service and its actual use. I could not judge.

9. Recommendations. I believe that the medical center could offer educational opportunity for the physicians in private practice in small communities, both by continuing the present postgraduate educational programs, and by devoting more of these to the general practitioner or family physician and also by continuing the Physicians-In-Residence Program.

Sincerely,

F. William Blaisdell

F. William Blaisdell, M.D.
Chief of Surgery

FWB:ch

Signed in his absence.

SAN FRANCISCO MEDICAL CENTER: SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

February 13, 1969

L. S. Kimbrough, M.D.
Project Officer
570-U

Dear Dr. Kimbrough:

Regarding my participation in the Physicians-In-Residence Program at Tulare on January 13-15, the following are the answers to your questions:

1. The level of practice in Tulare County Hospital was in my opinion very high. It is interesting to note that in an 80 bed hospital such as this, the Chief Surgeon and Assistant Chief Surgeon are both board certified surgeons, with the Chief Surgeon qualified in thoracic surgery and hoping to do a fellowship in cardiac surgery.

   I reviewed the patients in the surgical service and was extremely impressed with the surgical skills of the staff and the very fine post-operative care. The Department of Obstetrics and Gynecology was under the direction of a physician who is board certified and a member of the Faculty at Loma Linda.

   The Chief of Medicine was an internist and cardiologist.

   The Head of the Department of Pediatrics is not on the full-time staff of County Hospital. However, he directs the Department and actually hospitalizes many of the patients in the County facility because of its high level of care.

   The Orthopaedics Department is handled by board certified orthopaedists who visit the hospital as well as the surgical staff who are familiar with many of the minor orthopaedic procedures.

   Radiology is handled by visiting radiologists who are board certified in radiology. Facilities are excellent. The community hospital is staffed 24 hours a day by house physicians and the schedule of consultants is such that consultations can be obtained quickly when necessary.

2. The weaknesses as far as practice is concerned seemed to be that many of the staff physicians who want to do training in particular areas are often called upon to rotate through the various subspecialties. Unfortunately, the pressure of the patient workload is such that they are unable to develop the depth that one would expect to obtain in any subspecialty.

193

3. However, on the other hand this rotation through the various services keeps the men who are staffing the hospital fairly familiar at least with the routine problems in Medicine and Surgery.

4. The problem with the community hospital of this type is that patient workload is such that the physicians do not have the time or facilities for further educational exercises or time for continuing their medical education. I feel that the County Hospital really needs these continuing education programs in liaison with the University so that these men can be continuingly undergoing process and at the same time patient responsibility.

5. For a hospital of this area, I think they are doing an outstanding job. The laboratories could be automated to give a more comprehensive service to the staff. In addition, they might have full-time chief of pediatrics and orthopaedics. However, these are only minor problems. At present, because of the cooperation of the physicians involved in these areas these problems are not too serious.

6. The problems relate to the schism between the practicing physician and the county physician. It is very apparent that the introduction of specialists into the county hospital has created anxiety among the local practitioners.

7. Ancillary services were very effective units. The Laboratory, X-Ray and surgical services were very well organized.

8. I was very disappointed in the discussion relating to referrals. Physicians there had at once time a very warm feeling toward the Medical Center. However, in recent times, because their patients are being charged at a rate comparative to those of the private hospitals, they are reluctant to send them here. I see no reason why the University could not work out a better relationship between the Medical Center and County Hospital.

9. After working with these physicians for three days, I was very heartened by their warm feeling toward the Medical School. They do wish to feel a part of the School, but they are unable to get away for any period of time due to a heavy workload. Those of us who work at the University have no real insight into this problem. They cannot just leave their hospital since there is no one to replace them. The Medical Center must therefore be responsible for taking the education programs to them.

I feel very keenly that we can organize better post-graduate programs where our fellows, junior and senior faculty members and chief residents can take turns with working with the community. This would raise the education opportunities for the practitioner throughout the state, as well as train young men as educators.

I must say once again that this was a most gratifying experience for me. I now have a much better insight into the problems that these physicians encounter and I am most impressed with their hopes to keep up with modern medicine. I am most sympathetic to their problems and excessive workloads and do hope that the University will continue to find means of helping these men in their demanding requirements.

Sincerely yours,

J. Carbone

John V. Carbone, M.D.
Professor of Medicine

JVC/ej

REPORT ON PHYSICIANS-IN-RESIDENCE PROGRAM

Mercy Hospital, Merced
October 23-25, 1968
Alan Coleman, M.D.

CONFIDENTIAL

Level of Practice in the Community Hospital: I was at two hospitals, Merced General which serves as the County hospital but also has private patients. The other hospital was the Catholic hospital, Mercy. Merced hospital serves the community and I would compare it very favorably with the large city county hospitals. The hospital itself is a fairly modern structure, a new wing has just been added. The facilities are good, the layout is good. The situations of the patients in terms of the physical layout, the adequacy of the nurses is good. They seem to get good care at this level. The medical care that they get from the physicians is a variable thing. The care given to the indigent patients who are hospitalized at that hospital is supplied by the private physicians just as those of us in private practice here work in clinics. There are a couple of salaried physicians who work in the clinics. The care which they get I think is spotty. There are some good men and there are some who are not so good. At the level of individuals concerned, the individual physicians, is somewhat spotty. But overall probably good in a sense that there is clearly a high level of concern for the patient. The facilities which are available to them are good. The involvement by the physicians with the indigent patients is generally quite good. I thought that everything at this level was surprisingly good, surprising to me in that I thought that this general level was available only at the large county hospital, but this was wrong. In general, the indigent patients were taken care of pretty well, in terms of the medical care that they got.

Weaknesses and Strengths of Practice: The major weaknesses are that there is no organized body of physicians who are involved with these patients and nobody else. Most of the physicians were seeing the indigent patients down there. One of the troubles down there is the disorder of physicians. The doctors are very busy with their private practice. A couple of men who are salaried physicians, I think, are not terribly competent. I wasn't particularly impressed with them. On the other hand there are some first-rate interns who do have a lot to do with these patients and this is one of the strengths. The major weakness is that there is a very uneveness of physician quality. Those physicians who spend the most time with the clinic patients tend to be weak. There are enough good people around so that the overall quality of patient care is good. The major strengths, is that the hospital is basically a good hospital. The clinic patients are not getting short-changed. The physical set up of the clinic itself and the in-patient facilities is first-rate and a number of the people are first-rate. The major problem is an uneven quality of the physicians. Secondly, there is no sustained supervision. It tends to be somewhat uncontrolled in terms of the activities of the specific physicians.

Areas of Potential Improvement: I find it very difficult to state specific areas of improvment in this kind of situation. One tends to compare that kind of thing with a clinic situation and a big city hospital where we have a full time residence staff that's involved in their own learning process and is involved on a day-to-day basis in a supervised program. I don't think the leader of these kinds of things would be available down there. It might be of some help to pay the physicians in the community to supply their services to the clinic, for example MediCal. So many patients at the Merced County hospital are receiving welfare funds. I don't think there is anything unethical or anything unprecedented about paying private physicians for their care of County

197

patients. The difficulty with that, of course, is that these are very busy men who probably don't have much time. Actually, they have enough down there to have a bit of a teaching program. There's enough going on in their clinic and in their County hospital to actually support a small but vigorous teaching program, which would be fine if there were the supervision. One of the things that's lacking in this general set up is that there is an awful lot of supervision. Everybody down there is committed to the demands of their practices. If ways could be found of involving the private physicians with compensations, this would bring a higher level of involvement and interests to the activities of the Community hospital. I really thought that it was done pretty well, at least I was surprised. I had never seen a small city before and this is a pretty small town, but they do it well.

Improvement Clinically and Administratively of Medical Care in the Hospital: The administrator is a go-getter, who seems to be well liked by the physicians working closely with him, and is anxious to make the place good. He is sloward looking guy who was anxious to carry on building programs. Administratively, they seem to be pretty well set, with a good X-ray department, a good lab, limited but very adequate for their needs. Clinically, the patients get good basic care, not quite the same care that we would expect in a good big-city hospital clinic. Things fall a little bit short of that.

Problem Areas in the Community: There's a fairly large indigent Mexican and Black population. It's a town which has a very well-off upper middle class farming White population; people who are in the off-shutes of the farming industry, and then as I say a large indigent Mexican and Black population which serves as the back labor for the farming industry. As in most of these communities the Mexicans and Blacks are pretty much down and out. So far, the community seems to be moving along in its perhaps archaic rut. The modern revolution has really hit the town, and there doesn't seem to as yet been much uproar over education and jobs. I'm sure that this is going to come about. The White farming interests are pretty conservative and solidly entrenched, and against change. There isn't much opportunity for upward mobility for the indigent groups down there. I saw the poor sections of town but they didn't look all that bad. The "wrong side of the tracks" seemed to be okay from my White middle class mind, although I guess the people who were living there thought it was pretty lousy. Things looked satisfactory from the overall standpoint right now.

Use of Ancillary Services: Whether they are adequate I don't know. They do have social workers, County social workers who are involved with the patients, medical ancillary services like physical therapy and rehabilitation. These were good services. I suspect that there is a lot of the use of social services down there, because there is a large indigent population down there. The services are adequate and well used.

They refer a lot to Fresno and to some extent to UC. There tends to be a fair of disaffection with UC. They don't have good enough communication when they send a patient up to UC. They feel that things are being done to their patients without their knowledge, without their consent. Particularly of course with the private care patients. They utilize the services at the University, they frequently feel they have no choice. I think there's no question that they prefer to keep their patients close at home, and they do so whenever they can. They utilize referral services at Fresno to a greater extent, for the obvious reasons that they are closer and they know a lot of men there personally. One of the troubles in this community is that there just isn't enough men in certain specialties: for example, there's no ophthalmologist, or else there's one that's just completely overworked. There are two urologists. One of them just came within the past and one who just came. They are so overworked already, and making so much money that he really doesn't know whether to be ecstatic, he's so overwhelmed. There is a need for men in certain very specific specialties. They desperately need another dermatologist, more internists. There's an awful lot going on down there medically, so such men would be needed. At the present time because there's simply inadequate referral opportunity within the town they do have to send many routine referral cases to Fresno and many more specialized cases to San Francisco. They do this without being terribly pleased that they have to do it, they would prefer not to. That's not hard to understand. Part of this is inevitable because the University is the "big, dominant institution in Northern California. People tend to be resentful of something big. The University really has to be careful about maintaining proper communication on anything that happens to the patients who are sent up to them. I saw a couple examples of really just shoddy communication of patients who had been sent up to UC after prolonged hospitalization to be sent back either with no word or a totally inadequate mode of communication, which was unfortunate.

Ways the Medical Center can Meet the Educational Needs of the Physicians: There is an awful lot the Medical Center can do. I'm not sure if UC at San Francisco-is the institution to do this. If there were more going on in Fresno, Fresno is the logical place. In the coming years, institutions in Fresno out to be designated Regional Medical since this is a specific need. These sub=centers are the logical places to meet the needs of places like Merced. To be a little specific, most of the men in Merced are general practitioners and are very busy. I think that there is a clear dichotomy between the older general practitioners who have been out of practice 15 years or longer, than the younger

PHYSICIANS-IN-RESIDENCE

men who have been there for a shorter time. Most of them who have gone through GP have a fairly different approach. They are generally of very high caliber. Most of the younger GP's are well trained, have a lot of general knowledge. They are not just "fumbling along", but really have a lot of specific knowledge about an awful lot of things. They do a good job and are terribly concerned and really make a concerned effort to stay up with a lot of things. It's these guys who the Medical Center has to meet. The older ones are the GP's of the past. They are not terribly concerned or at least they're not any longer. Their training is really quite inadequate. The needs of the other GP's has to be looked to. These men are very responsive. They don't want their time to be wasted. They don't want to come to teaching sessions which are not of immediate practical value. They've got limited time, and they want to get something out of it. They will respond. I think that the three day course idea has value, it was an awful lot of fun. I think it was well received. This kind of thing when it's done on an occasional basis is good. Anything that's set-up has to be on a sustaining basis. There are probably a thousand little communities like this in Central California. To set up some kind of sustaining post-graduate program is awfully tough. If the University could begin to develop some program of regular scheduled visits to these communities, by clinical and regular faculty people, stressing the fact that these sessions should cover very practical topics; with a modicum of basic science thrown in. This would be enormously helpful. The idea of a weekly conference is great. Over a period of time, it would be enormously well received to set up a weekly conference. In the community they've tried to something like this, but it isn't very good. They have sort of one clinical conference a month, on a problem case which is attended by a dozen men.

PHYSICIANS-IN-RESIDENCE

This is simply inadequate. The television thing is great, and the radio is fair. There are a bunch of them that listen to the radio program every Tuesday, and some of them that regularly watch the T.V. program. It's clear that one really great thing for the future is the T.V. If good T.V. programs are scheduled for a regular basis, not necessarily produced at UC, but things which might be produced at any medical center throughout the Country had been available for distribution throughout Northern California as is now being down. I think that this is so valuable. To have somebody from San Francisco or up from Fresno and appear personally, this is good but it's inefficient. There are so many small communities in the area. The big push should be toward emphasizing the strengthing the television. You can build up a library of television tapes which can be used over and over again and can be reshown in a particular community if there's a demand for it. The radio thing from my own involvement, although it's so much cheaper it's just not nearly as good.

The other thing I was thinking of is the idea of bringing those men up to San Francisco for a period of time, of somehow enabling them to come up for several days for specific post-graduate courses; giving them the opportunity. But again, this is very inefficient and it's expensive. Post-graduate education is very, very important for these men and they get away from it very fast. There is no real pure evaluation. This is a very tricky subject. Perhaps, the ideal thing would be to have periodic licensure, but everybody is pretty much against that. Short of periodic licensure we've at least got to make efforts to bring the men in the community back into an educational program on a predictable and sustained, periodic basis. I think the one-shot or occasional two or three day thing has very, very limited value. There's got to be something going on, predictably and regularly. I would urge that just as much be pushed into the television thing. I know that more and more people are watching it, and it's becoming increasingly popular. It's a good thing that people are going to watch.

I thought this was a great experience, and I would do something different the next time I go down. I know much more now. When you first enter into this kind of thing, you just aren't really sure what the set-up is or how to arrange things. I loved the experience and I'd be delighted to go again.

Unfortunately, I didn't do anything which was directly clinical, but I would have liked to. It was all didactic talk. The time which the men had available, it was so structured so as not to remove the men from their private practices. Everything was built around meals. On a few days we met at 7:30 a.m. for breakfast and I spoke. We met everyday at lunch. There were a couple of things which were post-dinner. Things really seemed to have to be structured around the idea of not removing the men from their practices. If you start seeing patients, getting involved on rounds, it's more likely to run into the working hours. I certainly think this would be a fine thing to do, you've got to have the cooperation of the community. That ought to be stressed more if this program is continued for another year. There ought to be more clinical involvement. I saw a couple of patients by myself; I was supposed to see them with a couple of men, but they were called away. I spoke to them about the patients later. There's a problem with really stimulating a high level of interest among the physicians. The attendance of the talks varied from a dozen to close to 25, which was fine. There's a built in bias, and obviously you're only getting those people who are really interested. You're not touching the large portion of the community who probably really should be touched. Anything that's done on a sustaining basis will gradually begin to reject. Anything that's good will gradually being to reject more and more people, who will then will readily accept the idea of sacrificing an hour of their time if they know that they're going to get something good. Something directly clinical, seeing some patients, would have been fine. We did touch on a lot of clinical things; there was a lot of questioning from the floor about clinical problems,which was helpful for everybody. In this sort of thing, you will always have a lot of questions about very specific clinical points. There was a lot of opportunity to go into clinical problems, even though we weren't actually seeing patients.

Report on PHYSICIANS-IN-RESIDENCE Program
Washoe Medical Center, Reno
June 12-15, 1968
Dr. Douglas Crowther

CONFIDENTIAL

Dr. Kimbrough: I would like for you to answer this question: do you feel that your trip was a success or not?

Dr. Crowther: Yes, I was impressed with the fact that they had things arranged there for me and they had several talks to groups involving outside people. They all seemed to attend these talks. They all seemed to receive them well. I felt it was quite a profitable three days. Not only was I associated with children but I was associated with adults so that as far as Peterman and myself were concerned, he seemed to be the coordinator for the program. He had arranged that I go on ward rounds at the local hospitals there and meet some of the people and discuss some of the problems there. I thought this was a reasonable thing. I suppose the total time would be two and a half days, as far as the work was concerned because on Friday I was free by lunch time. But the other two days were taken up with fairly reasonable number of meetings, I thought.

Dr. Kimbrough: What did you consider, judging from the questions you received, to be the major areas of weakness in this hospital?

Dr. Crowther: The two broad areas that I was covering in terms of my talks were learning problems in children, and of course, they have as many questions up there as we do in California. I'm not sure that I'm going to be able to answer all their questions, any more than anyone else can, so I'm not surprised that they are "weak" in that area---everybody is. The other question is pediatric health convulsive disorders and I felt that they had the same sort of questions in regard to health disorders in general, not just pediatrics, that everyone else has. These were two areas that I thought could be reinforced but neurology in general was well received there, it was my judgment. I seem to feel that they had a need for more neurological aspects to be discussed and again I suppose that Dr. Peterman being the neurologist, he would be the one to contact about that. In particular, I think they felt the need of a pediatric neurologist because they don't have one up there and of course, they do have an adult neurologist.

Dr. Kimbrough: Did you have a chance to . . . I'm sure you did since you probably saw patients . . . what do you think about the charting? Was that up-to-date or was there a weakness there?

Dr. Crowther: The charting itself?

Dr. Kimbrough: Yes.

Dr. Crowther: Oh, I'm afraid I didn't go into that. They presented the patients to me as a clinical problem and I didn't check the charts at all.

Dr. Kimbrough: Now, about the questions you got. Were they intelligent questions? One of the other problems that some of the other doctors have been reporting has been that they were somewhat behind the times, in that they didn't have even an up-to-date vocabulary in speaking of modern medicine.

Dr. Crowther: Well, you see in an area like this you really have a disadvantage. You see, what happens is that your coordinator is a specialist in your own area. In my case, Al Peterman is a neurologist, so there is no problem in communication as far as the two of us are concerned. But then when you are discussing things with people who are out of your own specialty, they show a woeful lack of knowledge. This again is not unusual. They are general practitioners for the most part. Then of course, their questions are very general. They need a lot of up-to-date information, very serious. So I would agree with the others who have commented in this area.

Dr. Kimbrough: What about the potential for referrals? Is that there, or do they try to take care of these problems within their own community?

Dr. Crowther: Well, I can't speak about other people. I know that I get a referral from Peterman maybe twice a year and that they are, of course, children. As far as I know, Peterman refers to Don McCrae in neurology several times. I don't know how many times but McCrae would know. That is just one guy referring neurological problems and I don't know how many problems there are in other areas. Not a great deal. I would say in neurology it is a very small amount.

Dr. Kimbrough: Well, if you could sum up the positive things you accomplished up there, how would you?

Dr. Crowther: I would say that there was a good reception to the program. The people seemed to enjoy the subject matter that I was presenting and they seemed to have intelligent questions in regard to the subject matter. As to whether they seem to need more of the same thing, I would say they probably do.

Dr. Kimbrough: Now of course, this is just one of our means of getting to people. Now, how do you judge the effectiveness of this over radio and TV, and over the one-day circuit courses which we give? How would you compare these?

Dr. Crowther: Well, I don't know how you evaluate your radio programs and what methods you use to evaluate them. I have no means of knowing that. I've taken part in one of them on Pediatric Neurology . . .

Dr. Kimbrough: It was a very good one, incidentally.

Dr. Crowther: I don't know the feedback on those but I know the positive effect when you are facing an audience. You can feel it. I don't know how one judges the radio program as distinct from that. . In fact, I don't even know how one judges the long term value of these programs. You are the expert in that area, of course.

Dr. Kimbrough: Well, we certainly hope that next year, approximately one year from your first visit, we'll have you go back and see if you've effectuated any changes at all in the attitudes, etc.

Dr. Crowther: Well, I think in the area of the learning problems of children, this is a very big social area, as you know at the moment. We've had many programs on the calendar. Dr. Gofman is always having programs in that area and this was the area in which I noticed the greatest interest for non-medical personnel, of course. All the school personnel seemed to turn up in force, and all the psychologists turned up from the Nevada State University. Their questions were very penetrating and I thought very good indeed as they are at many meetings here.

Dr. Kimbrough: I didn't realize you had that big an audience.

Dr. Crowther: Oh yes, well that big, it seems . . .

Dr. Kimbrough: But that wide a spectrum . . .

Dr. Crowther: Yes, there must have been 30 or 40 people at one of the meetings I had there and they were all professionals in the field---no public. So they obviously showed a very great interest in this particular area, presumably because they are getting into it and haven't got the advice of professionals like they have down at Cal to advise them on how to approach some of the difficult problems. So that was the big area like it is everywhere else.

Dr. Kimbrough: Any more comments?

Dr. Crowther: None. They were asking me questions about how to apply for research grants in terms of NIMH, which I thought was somewhat inappropriate and I did not know how to advise them on that. I thought their efforts in neurology from the point of research were very primitive. They are not set up to do much research in neurology. But as far as I am personally concerned, I enjoyed the meeting and I thought it was profitable.

Dr. Kimbrough: Judging from the questions you received, could you give us a rough breakdown on GP's, neurologists, etc.

Dr. Crowther: I can't. As far as Peterman is concerned, he's the only neurologist in Reno and he was the one who was coordinating the program. He works with Adolph Rosenhauer, who is a neurosurgeon, and of course, there is another neurosurgeon in the area. He was present at the meetings so that neurology and neurosurgery, as is in Reno, were well represented at these meetings. I had a meeting with the Pediatric Society there, and we discussed problems of convulsive disorders in children. They seemed very receptive to this and they seemed to have some good questions in regard to it. The other people were, for the most part, an occasional general practitioner and many school people, and no paramedical people.

Dr. Kimbrough: Well, marvelous. I gather you enjoyed your trip. Did you get your funds?

Dr. Crowther: Yes, I enjoyed it very much. I am very appreciative. Thank you.

SAN FRANCISCO MEDICAL CENTER: SCHOOL OF M
OFFICE OF TH

February 7, 1969

L. D. KIMBROUGH, M.D.

My visit to Redding was a one-day affair under the auspices of the Physician's In Residence Program. I was interested in and did participate in the scientific aspects of the visit but I was equally interested in developing contacts for the School of Medicine and in informing practicing physicians about what was going on at the School of Medicine. As a result, I am unable to answer most of the questions you posed.

It was obvious that the group with which Doctor Lee and I met, which apparently was the Medical Staff of the Redding Community Hospital, is definitely oriented toward the UCSF Medical Center. This is due to the presence of several graduates both from medical school and from the residency programs. There was an apparent resistance to the proseleyting attempted by Davis. Steps are being taken to exploit this interest in UCSF both from the standpoint of referring patients and the RMP.

UCSF can bestmeet the needs and interests of the physicians of the community in education by continuing the visits through the Physician's in Residence Program and by involving them in the RMP Area I. It was evident at the visit and later at the Evaluation Conference that this community and the physicians with whom I came in contact were enthusiastically in favor of the Physicians In Residence Program and I believe it is one of the better means of satisfying their educational needs.

Stuart Cullen

Stuart C. Cullen, M.D.
Dean

SCC:BG

211

Report on PHYSICIANS-IN-RESIDENCE Program
Redding Memorial Hospital, Redding
Richard G. Devereaux
September 25-27, 1968

CONFIDENTIAL

Dr. Kimbrough: As you know, Dr. Wilson and I are involved in the Physicians-in-Residence Program. Let me first ask you how was your reception at the hospital?

Dr. Devereaux: I thought the reception was excellent. They were very cordial and anxious to show me about and hear what I had to say.

Dr. Kimbrough: What would you say about the level of practice in that Community hospital?

Dr. Devereaux: I would say the level of practice was generally quite good. They seemed interested in keeping abreast of current developments in medicine and applying them. They have rapport among the staff and seem to work well together. They try to employ the latest methods wherever possible.

Dr. Kimbrough: Did you notice any weaknesses as far as the level of practice? Obviously there is a weakness because you were up there as a gastroenterologist. Was this very paramount, was this very obvious to you that they were weak in this field?

Dr. Devereaux: Not particularly. They in fact,had just recently purchased a gastroduodenalfiberscope. There were two men who had had some training in using it and were anxious to gain more ability with it. I would say the most obvious weakness in the educational program is simply that they do not appear to have as much organized teaching as they might have. They apparently only have a departmental staff meeting once a month at which time an interesting case may be presented, but there are no regular CPC'S or regular staff rounds that I am aware of.

Dr. Kimbrough: What about the areas of potential improvement. You touched on this, of course just now. What do you think clinically could be done to improve the medical care in the hospital?

Dr. Devereaux: Actually, I would feel in a situation such as the one that they have up in Northern California that probably the best method is the one that is currently being employed only perhaps more intensified, in getting more people up there to give them regular lectures and case discussions. They turned out very well for the lectures that I gave and seemed very interested, there was a very good question and answer period afterwards, and the questions seemed quite penetrating.

Dr. Kimbrough: What do you think that the administrator can do to improve the hospital, or do you think he is doing a good job?

Dr. Devereaux: It was my general impression that the administrator is doing a very good job. He keeps close contact with the various staff members and seems quite conscious of the newer developments in the general fields of medicine, certainly, and seems quite interested and anxious to obtain the newer procedures and equipment for his hospital.

Dr. Kimbrough: Did you notice any problem areas in the community itself? Problem areas as they relate to your speciality?

Dr. Devereaux: No, not really to my speciality itself, speaking as a sub-speciality. The greatest problem in the medical community appeared to be that of obtaining good nursing personnel and personnel that remain for any period of time.

Dr. Kimbrough: What about the use of ancillary services? Are these adequate, up-to-date or below par?

Dr. Devereaux: I'd say they are adequate. They just recently purchased a computer type machine in the laboratory for doing panal chemistries, as well as a new machine for doing the rapid and accurate electrolyte determinations. They have the radioisotope program there where they can do thyroid scans. They've done some pulmonary scans and brain scans.

Dr. Kimbrough: What about the referral service and its actual use.

Dr. Devereaux: It was my impression that they use the referrel service quite readily. More than one physician talked about cases that he had recently referred down to the Medical Center. One in particular was the neurosurgeon, Dr. Stevenson, one of whose cases I had an opportunity to meet, and who had just returned from the Medical Center having an evaluation in neurosurgery.

Dr. Kimbrough: This is a big question in recommendations as to methods by which the Medical Center can best meet the educational needs of the physician and the community.

Dr. Devereaux: I would say that this particular program that we're trying at the present time would seem to be, as far as I can see, probably one of the best means of doing this. As I say, they seem to accept it very well. They seem to have gotten a lot out of it, even to the point of photostating one of the reprints that I brought up there, and recording my various talks for other members of the staff that couldn't make it. Generally,I think this is one of the better ways.

Dr. Kimbrough: In one of the states here on the West Coast they're sending out physicians to spend a few weeks time out in communities such as Redding and so on.. Do you think that possibly after this type of program has gone on, that this might have some appeal with doctors here in the Medical Center to go out and spend say two weeks taking over the practice of one of the physicians up there? Do you think that would appeal to the doctors---do you think that would be effective in this state?

Dr. Devereaux: It might appeal more to the full time staff members of the Medical Center. Speaking for myself as a clinical staff member with my own private practice, this just doesn't appeal at all.

Dr. Kimbrough: What about the sphere of influence up there? Do you think that they tend to look to the University of California here in San Francisco, or do they look to some of the other universities?

Dr. Devereaux: It was my impression that they sort of share it fifty-fifty between the University of California and Stanford. They've had several of their people up there who are Stanford trained. Although I know of no specific instances where Stanford has sent up any visiting speakers.

Dr. Kimbrough: Is there a Director of Medical Education present up there?

Dr. Devereaux: No, there is none.

Dr. Kimbrough: Did you have any chance to talk with the clinical pathologist, and what do you think of his competence?

Dr. Richard G. Devereaux:

Dr. Devereaux: Well, I really spoke only very briefly with their clinical pathologist Really, I can't make a good judgment of his competence.

Dr. Kimbrough: What about the projective growth pattern, and I'm speaking particularly of gastrointestinal--GI disorders--your speciality. Do you think that it will grow, or do you think that possibly you had some influence on them?

Dr. Devereaux: That's hard to answer definitively. There was one internist there who stated that he was very much interested in gastrointestinal disorders per se, he appreciated the presentations that I gave very much, and in addition brought other problems to my attention that had been troubling him in the gastrointestinal line. Not only he, but at least one or two others brought their own personal gastrointestinal problem patients to me for impressions and recommendations.

Dr. Kimbrough: What would be your recommendations now that you've had a chance to spend three days in this hospital? Do you have any recommendations to make--overall. Are they keeping their medical records up-to-date? If you were the Chief of Staff in this hospital, what major changes would you make?

Dr. Devereaux; I think the main thing would be to increase the number of teaching conferences or meetings on a regular basis. I couldn't see where they had a regular teaching conference or meeting at any short term intervals.

Dr. Kimbrough: What about the attendance?

Dr. Devereaux: The attendance was excellent. There were no empty seats that I could see.

Dr. Kimbrough: As you know, this is a project running three years and we would like for you to go back in September, 1969 to see if you had an impact on them. Would you like to go back?

Dr. Devereaux: Sure, I'd be delighted.

Report on PHYSICIANS-IN-RESIDENCE Program
Scenic General Hospital, Modesto
Dr. Vincent C. DiRaimondo
May 13-15, 1968

CONFIDENTIAL

Dr. Kimbrough: First question, Dr. DiRaimondo, I assume that you had a successful trip down?

Dr. DiRaimondo: Yes, everyone was friendly and attendance was reasonably good at all the scheduled teaching programs.

Dr. Kimbrough: Speaking of the level of practice in the hospital, could you point out some of the weaknesses as you saw them?

Dr. DiRaimondo: The internship and residency program at Scenic General Hospital was somewhat weak. One of the problems in conducting teaching rounds for these people was that the coverage was so scanty that they were unable to pull enough people off the wards to attend rounds, etc., so that teaching could be effective. Half their staff had to stay on wards and care for patients and could not get away for teaching programs. This was the only hospital in which I got to know something of the hospital staff in terms of the interns and residents.

Dr. Kimbrough: Now, did you notice anything in which you would say they were up to standard? What were the strengths which you observed?

Dr. DiRaimondo: Well, in discussing the patients who were presented, the patients who were presented in my area were presented in terms of the house staff. They presented a patient with pancreatitis and diabetes, a couple of diabetics with peripheralvascular disease, and as far as an understanding of fluid and electrolytes, they were not very good.

Dr. Kimbrough: They weren't?

Dr. DiRaimondo: No they weren't, plus the fact that in trying to discuss and electrolytes using modern terminology, the house staff was also quite weak.

Dr. Kimbrough: We've heard this comment from Exeter that they don't even have a modern vocabulary.

Dr. DiRaimondo: That's right.

sodium potassium water, etc. These are based on their impressions more than really sitting down and calculating these things out.

Dr. Kimbrough: What recommendations would you have in terms of administrative or clinical improvement?

Dr. DiRaimondo: As far as the house staff?

Dr. Kimbrough: Right.

Dr. DiRaimondo: One of their problems, of course, is to be able to attract a good house staff. They are having difficulty in getting a house staff to cover Scenic Hospital. That's number one. Most of the time, the sort of people they attract are the people who might be interested in practicing in the area. In one area, surgery, there was apparently rotation of the surgical resident who was on the Stanford service, I think. He was sent out to Scenic to gain experience in surgery in that particular hospital and he was having lots of work to do. There was another resident who was particularly interested in vascular surgery and with Dr. Goldbraith as a preceptor, this individual was getting considerable experience in terms of procedures, etc. Except for these two bright lights the staff in general was relatively weak, and I think this is primarily because they couldn't attract a good house staff to begin with. If you don't have enough of a house staff, then the teaching gets sort of lost in the shuffle. Although they have some good visiting physicians at the hospital, there is a problem in terms of having enough house staff and enough of a coordinated program to really do some teaching.

Dr. Kimbrough: What recommendations would you make there, either to the Chief of Staff or to the Hospital Administrator, that would meet the needs in this hospital?

Dr. DiRaimondo: The key to the whole thing is attracting a sufficient number of house staff, in addition to getting topnotch house staff. This is where the problem is---being able to attract the appropriate type of house staff. To begin with, the house staff is somewhat weak.

Dr. DiRaimondo: Because most of the topnotch people go to University Hospitals and end up in some speciality training. These people were primarily interested in general practice and have general internships except for the surgical people who are on loan from other institutions or universities. You have primarily a group of interns who were interested in rotating internship or general practice in anticipation of general practice. I would suspect that this would reflect weaknesses in teaching programs. This is why they are unable to attract people, unless people come from the area of Modesto and are interested in practicing in the area. These are the people that come back and get their training in this particular area.

Dr. Kimbrough: What about the Director of Medical Education? Do you think he is doing an adequate job?

Dr. DiRaimondo: Well, he's a very quiet individual and apparently he is an able administrator. I don't know how much medical teaching he does. I would suspect that he does not do much teaching on his own, but is primarily a coordinator of the educational efforts. This particular individual at Scenic was previously in surgery. and it would probably be much better to have someone in medicine, and interested in medicine, who could handle more areas and probably do more teaching on his own. From what I gather talking to him, he was completely dependent on his visiting staff and outside people to do most of the teaching. He was more of an administrator than anything.

Dr. Kimbrough: Do you see any potential for referral in this hospital?

Dr. DiRaimondo: Referral to what center?

Dr. Kimbrough: To the major centers---cases which they can't handle. Or do they try to handle difficult problems themselves?

Dr. DiRaimondo: I think since the county hospital is used also as a community hospital---that is, in the sense that there are private patients who are seen there---that there might be some patients who are referred to the university center. I would say that a large percent of these people will be taken care of by the visiting staff referrals but not as many as one might think.

Dr. Kimbrough: Two more questions, now. One is on charts and the other one is on ancillary services. What's your impression?

Dr. DiRaimondo: The charts were adequate. I think they satisfied all requirements. They kept good records, limited by how much medicine they were aware of. Some of the other hospitals which I saw . . . unfortunately I don't remember the name of the hospital.

Dr. Kimbrough: But it's in the Modesto area?

Dr. DiRaimondo: In the Modesto area, private hospitals were generally good. They have a good group of doctors in the area who can handle the situations. They have some good internists, good radiologists, good neurologists, and some good surgeons, including competent vascular surgeons. So in general, I would consider the medical community, in terms of the physicians who are available, very good. The big problem is having enough of these people to participate in teaching programs in the county hospitals. I think one of the problems is that they can't get off the ground in terms of getting a worthwhile house staff to begin with.

Dr. Kimbrough: So then you decided the ancillary services are, from what you saw, good. Would you mind going back one year from now? There will be someone going out every four months.

Dr. DiRaimondo: I would love to go back and see if anything is changed or if there are improvements. I went through three different hospitals in surrounding communities and, unfortunately, I can't remember all the names of these hospitals. Cases were presented usually in anticipation of the area in which I might be able to contribute, but I would have liked to have gotten more general types of problems to see how much they know. But in general they did a good job. I was impressed by the number of people representing different areas who could really handle different areas, so that they were reasonably self-sufficient in terms of available consultations. One of the problems in conducting this sort of a teaching program is---

since the teaching takes place during the daytime---the extreme difficulty of getting these people together because everyone is involved in private practice. They have committments in the clinic, group practice, and what have you, and its hard to get them together. One has tried to make the program a little more effective by going to each of the hospitals so that one ends up talking to local people and covering everybody in the area. But he only talks to them once or twice at the most, although he spends three days there. So that one has limited exposure to the individuals, and one has limited exposure in terms of what they have available. At one conference, they had presented a patient who had been seen at the University of California. This particular patient wasn't particularly well diagnosed. The referring letter from the University probably was somewhat deficient in the sense of trying to teach these people, and suggest things that they might follow in addition to just making a diagnosis. To be sure, the patient was somewhat complicated, but I think in general they could afford to have more teaching. The big problem is to have more exposure in terms of contact with each of the doctors for a longer period of time. They are so busy that in three days one probably talks to some of these people just once. Other people you may talk to two or three times, but for the most part, most of these busy people are so busy that they can't take time off and so you'll see them once, or have exposure once at one conference or a session at a hospital. I don't know how you're going to get around this, but they're interested in learning. They are very eager to learn. The sort of teaching that one can do is relatively limited in a sense. One can only cover certain areas, and most of these people are exposed to only one teaching session---one conference. I think it's a worthwhile project. It would be much better if one could overcome the problem of attendance and have all of the people in the area in one spot so that they would have more frequent exposure to whatever was being discussed. This is the problem.

Dr. Kimbrough: I hope we can clarify that and get a better attendance for the next person going down.

I thought that with the exposure that I had, it was reasonably successful. I have received a couple of letters from some of the doctors to whom I had spoken. They were very enthusiastic about the program. It is primarily for the local doctors. There is not that much house staff around because the hospitals are understaffed and they are having difficulties getting doctors.

SAN FRANCISCO MEDICAL CENTER: SCHOOL OF MEDICINE

January 9, 1969

Miss Virginia Finley
Program Representative
Medical Radio Conferences
570 - U
San Francisco Campus

Dear Miss Finley:

As a Visiting Professor at Stockton, December 18-19, 1968, I presented seminars both at the County Hospital and St. Joseph Hospital. On three occasions, I saw and discussed interesting patients and the rest of the time I gave talks on selective discussions, including an after dinner talk at the Medical Association in Stockton. Talks ranged from the "Treatment of Diabetes" and the "Treatment of Obesity" to the work of the hirsute woman and the problems of osteoporosis.

Attendance ranged from 50 to 100 and there was excellent discussions. I since have received 8 spontaneous letters from the professors thanking me for my efforts which were extremely well received.

During my after dinner talk it became quite apparent that the men were very sorry to learn that this program is on its last legs.

Enclosed you will find an expense account.

My best wishes.

Yours sincerely,

Peter H. Forsham

Peter H. Forsham, M.D.
Professor of Medicine & Pediatrics

PHF/gcl

Enclosure

UNIVERSITY OF CALIFORNIA—(Letterhead for interdepartmental use)

Report on PHYSICIANS-IN-RESIDENCE Program
Mendocino State Hospital, Ukiah
May 22-24, 1968
Dr. John R. Gamble

CONFIDENTIAL

Dr. Kimbrough: What are the strengths and weaknesses of the level of practice?

Dr. Gamble: I think the level of practice is fairly high. This is largely due to the stimulus of the board surgeon who was there ten to twelve years ago, and two board internists who were there the last five to six years, and they have organized a weekly conference where they discuss mutual problems. They have a radiologist who comes to this and any difficult case that is presented there is sort of for free consultation. It has stimulated the general practitioners in the area to bring their problems cases to this particular conference. And then they have a mutual discussion and so the level has been considerably elevated by this.

Dr. Kimbrough: You said that the level is kept up because of the fac they have some board certified people in the community. This is one of the reasons for us getting involved in this program---that there are obviously certain weaknesses, which you no doubt were able to observe. And you can be candid about this. Recommendations will certainly be made to the hospital administrator, and the chief of staff and so on, and no names will be mentioned. You don't have to worry about being embarrased for revealing things which you might say

Dr. Gamble: Well, I think that the weaknesses are related to the geographic area that's encompassed. The people who are involved come to these conferences from Fort Bragg, which is an hour and a half drive on one side, and from Lake County on the other side, and

Ukiah is sort of the Medical Center for this community. To the south is Santa Rosa, and the orientation is in that area, and in the north---just not much medicine going on there. I went over to Fort Bragg and had a conference late one afternoon with the doctor in Fort Bragg. There are two privately owned hospitals in Fort Bragg, although a new hospital is going to be built in the next two or three years I think. A community hospital, I believe. But the level of practice in Fort Bragg---the contrast here is quite fascinating. It's really quite good in Ukiah. I was really surprised at how good it is. But in Fort Bragg, it is awful. This is historically. Fort Bragg is controlled by a lumber company and they have a few doctors around there and each has his hospital. They didn't get along, so there was no community feeling among the doctors and no communication. They just went practicing along their own merry way. The level there was pretty poor. I think it's improving because recently, a board surgeon a young board surgeon, went in there. He's only been there a year or two, and already conditions are improving because they have plans for this community hospital where they can get together and talk and discuss each other's cases. There was no monitoring because of this particular conference. It seems funny that one conference could do so much, yet there it is doing a great deal. But as far as specific things, I couldn't say anything in particular. I was just looking at the overall picture rather than any specific thing---whether the halls were clean or anything like that.

Dr. Kimbrough: Now what about the areas of potential improvement, clinically? Did you see anything, clinically, that you would like to see improved? And then I'd like to know whether you saw anything, administratively, to be improved?

Dr. Gamble: The problems these fellows have are largely concerned with communication. They feel quite isolated from San Francisco and even though these three board men are practicing a very high level of medicine, they are not sure that they are doing properly. In other words, they have no one to talk to, to reassure themselves, whereas the general practitioner in the area has these board people who they feel are satisfied. These fellows are just not sure what their level is. They have nothing with which to compare. The thing that they were particularly interested in, when they would present cases to me, was my reaction as to how this case was handled. Actually, I had very little criticism of the way they'd handled almost all of their cases. And some of the cases that they presented on a particular subject may have been two or three years old. But it was something that had interested them at the time. Everyone remembered so they presented this to see how it could have been done better. In just two or three years, you could see that they had picked up some of the new methods of GI diagnostic techniques that they hadn't had two or three years ago. They said themselves, "if we'd had this case now, we would have handle if differently." But again, they have picked this up from reading and you were talking about specific weaknesses. This is one thing that occurred to me there---I checked on their library, and the County Society has practically no library. The one library is at the Mendocino Hospital which is where our meetings were held. And that library is pretty inadequate. And it seemed to me that this was their real decision, as far as that area goes.

Dr. Kimbrough: I see, becuase I was going to get to the ancillary services. That's one thing, then, that is weak. What about administratively. Is the hospital properly administrated in your judgment?

Dr. Gamble: Yes, as far as I could tell. I have no criticism on that. Of course, I spent very little time in their hospital because their meeting room is at Mendocino State Hospital---the large conference room they have. They had no conference room at their own hospital. State Hospital provided them with this conference room, which they used regularly, and it's out of Ukiah a couple of miles, I guess. Nevertheless, it's sort of a medical education center.

Dr. Kimbrough: Did you have a good audience?

Dr. Gamble: They thought it was very good. You see, this is a very small group and they are scattered from Lake County to Fort Bragg. There were between fifteen to twenty five persons there all the time, which they thought a very good group.

Dr. Kimbrough: That's very good. I know you mentioned before what you consider the major problems in the community. You mentioned Fort Bragg, where you have your individual doctors, building up their own private little clinic. Did you notice any other problems in particular?

Dr. Gamble: The major one is just communication. I asked them for instance, what medical education of the University could do for them. They felt that sending someone out such as I, perhaps once a month for a shorter period of time---maybe for a day---would be a very good idea.

Someone in a special field, and then they could get these cases together. Some said that once a month was too often, it would be better every three months, or something like that. When I finished the last day, I got them into a general discussion of what could be done to improve the whole situation. They felt that formal lectures were no benefit, they they could get this any place. I talked to them about television and they felt that if Grand Rounds could be televised, this would be very helpful. They thought the formal lectures on television were of no interest. Their problem is not learning the details of better metabolism, for instance. They want to know how to take care of this particular problem, and how to do it in the best way possible. There is knowledge that they need that is practical now---what modern day methods supply. This is where they felt their greatest need was.

Dr. Kimbrough: This, I think, is slowly coming through to us. That this has been the big problem with television . . .

Dr. Gamble: It was really fascinating for me to hear all of this because I hadn't really been aware of their problems particularly, either. I can see now that living in the city, we don't realize this. We have somebody to talk to all the time about a problem and they just don't have anyone to talk to.

Dr. Kimbrough: They have some of these very decisions to make on their own.

Dr. Gamble: Yes, and they like assurance of whether it's right or could it have been handled better, one way or another. They feel only an expert can tell them this and he can really only apply his mind to this thing if he's sitting there with them---with that particular problem.

Dr. Kimbrough: Well, that's quite interesting. What about the use of ancillary services, and are the ancillary services up to par? The labs?

Dr. Gamble: The lab facilities are quite excellent. The pathologist's was very good, and the radiologist's was excellent. I was very surpris with the level of radiology. It was just outstanding. Usually we tend to look down on radiology in the hinterlands. I have great respect for them, for doing what they can do.

Dr. Kimbrough: What about the potential for referral in the ancillary use. Do you think they actually refer cases?

Dr. Gamble: Yes, they do. They refer difficult cases sometimes to Santa Rosa, sometimes to the city. They use this fairly well. Now, the ordinary thing, they feel they can handle themselves, and they can. At least two internists are certainly relatively well qualified.

Dr. Kimbrough: In some of the other visits that we had, Doctor Gamble, especially down in Exeter and Tulare, the doctor said that the doctors who were practicing there were still practicing the type of medicine they practiced twenty or thirty years ago, and that they had no up-to-date modern vocabulary. Did you find this to be true in Ukiah?

Dr. Gamble: Well, I think this was perfectly true of the older general practitioner. You could tell this by the questions they asked, but the younger fellows, in particular the ones that come to the meetings, are the ones that are interested anyway. They have been updated and pushed along by the stimulus of these three guys. I felt this was very interesting---what could be done with the vigorous, interested surgeon and internist in a community. I'm sure that if these three fellows hadn't been there, that things would be quite different. That's why I drew this contrast with Fort Bragg. Over there the way medicine is practiced is really way out of date, but I'd not like to be quoted on this. I think it will change when this community hospital gets going.

Dr. Kimbrough: Well, I might ask you this question: do you think that Fort Bragg could use a program of this nature? We can expand this program, I think, without any difficulty.

Dr. Gamble: I think if it could be combined, which is what they did with me. Part of the time in Ukiah and then spend a half a day in Fort Bragg. This would work out very well.

Dr. Kimbrough: I did forget to ask you one question: did you notice if the charting was up-to-date or adequate?

Dr. Gamble: It was alright. I didn't pay a great deal of attention to that, actually.

Dr. Kimbrough: You know our grant is running for a period of three years, and we would like to send the same professor back one year from the date that he was there. Would you be interested in going back and seeing if there has been any major changes as a result of your visit?

Dr. Gamble: Sure, I think this would be . . . would you want exactly one year, or . . . ?

Dr. Kimbrough: Approximately one year. Every four months, of course, we are sending somebody else up there. Now, any final comments, or any suggestions for any of these things that you've mentioned?

Dr. Gamble: Well, I think the main things that I thought about were the suggestions regarding the means of teaching. These fellows really want communication, and it seems to be best handled by someone going out there on a more frequent basis, probably on a shorter period of time. And they need this not only for reassurance but just for plain information. They don't want alot of formal lectures on this and that.

Dr. Kimbrough: That's almost been the consensus. Do you think that three days . . . I assume that most of your mornings were occupied, and probably your afternoons, you were pretty free were'nt you?

Dr. Gamble: Well, you see, all morning was occupied from nine until one, and this was continual. It seems like sort of a strain but when you get right down to it, it wasn't because they would present---they did this very well---they would present a group of three or four patients who had a gastrectomy, and the problems that had arisen with the gastrectomy. So they were all grouped together and then they'd present the problems with the hiatus hernia, the next hour---and something like that. So by the end of the morning, because I was talking, I was a little tired. Now, one afternoon I did go to Fort Bragg, and part of that was pleasure and part of it was a conference. So I think if they had more frequent visits, that this would be for a shorter perio of time. From my viewpoint, being gone for three days is quite a long time.

Dr. Kimbrough: It certainly is. I agree with you there. Well, we hope, as a result of this, to find out a good many things. I think we find that the level of practice, throughout the communities in California, and I assume elsewhere, is certainly low standard. That it can be improved by alot of people such as yourself who are willing to teach these doctors, and that overall it's going to improve this type of medical care in this country and especially in this state.

Dr. Gamble: Well, I think it will, and to me, it was quite a revelation to see what their problems were because I'd read about this. It just hadn't really sunk in, until I was out there, seeing their problems and talking to them. This was very worthwhile to me. I have a much better understanding of what their problems are and the better way to teach them. To bring them up to date, or whatever you want to call it. They are just not going to respond to an attending course, although many of them have attended courses. But of course, we tend to teach this as though we were teaching medical students, rather than practicing physicians.

Dr. Kimbrough: You know, incidentally, they've been rather loyal to us---to our medical radio programs.

Dr. Gamble: Yes, they like that.

Dr. Kimbrough: You know, as a matter of fact, we talked to Dr. Lein at the University of Washington, and they are joining with us in radio. I think we got a letter off to you asking for suggestions for topics for this coming year. Aren't you Chief of Staff at Presbyterian?

Dr. Gamble: It came just before I left. I turned it over to Arthur Selfrin.

Dr. Kimbrough: You'll be back on the ninth?

Dr. Gamble: Yes sir.

SAN FRANCISCO MEDICAL CENTER: SCHOOL OF MEDICINE
DEPARTMENT OF SURGER

February 11, 1969

L.S. Kimbrough, M.D.
Project Officer
Continuing Education in Medicine and Health Sciences

Dear Dr. Kimbrough:

The following serves as my report to you concerning my visit as physician-in-residence at Marysville on January 23-24, 1969. My visit consisted of making ward rounds with the doctors at the Yuba County General Hospital and the Sutter County Hospital, speaking before the staffs of both hospitals, holding a clinic at the Sutter Hospital, and speaking one evening to a group of approximately 40 or 50 nurses on the care of the patient in the Intensive Care Unit. Cooperation and interest were displayed by everyone contacted. I also visited the two private hospitals in the area.

The level of practice in these hospitals was high. I was impressed by the thoroughness of their clinical investigations and the available laboratory facilities, the accuracy of them, the cleanliness of the hospital, and the quality of nursing care. Intensive Care Units and Recovery Rooms and Coronary Care Units were fairly well conducted. The majority of the doctors were of the "younger" group with modern indoctrination and interest in learning. As far as 'strength of practice' is concerned, the patient belonging to a doctor through thick and thin, even though consultants are called, seemed advantageous. The only weakness which I could ascertain was that although there are many specialists there, they must do some things that they have little preparation for. I was impressed that these doctors are anxious to keep up to date and would welcome any effective continuing education with this in mind.

The Yuba County and Sutter County Hospitals should be united. They are two miles apart; the Yuba County Hospital is old and outmoded, the Sutter County Hospital is new and modern. Transportation is no problem. Both of these hospitals have full time medical men and yet the cost per patient per day is high because of the low census. There is a close liaison between the ancillary services and the medical profession. The nursing service receives considerable instruction from the medical staff and they in turn are likewise anxious to be brought up to date.

As far as recommendations are concerned, I would think that the Physicians-in-Residence Program is successful in this area. They are anxious to have informal, practical instruction with patients as we carry out both graduate and undergraduate in section work. It would seem to me that this type of teaching can be carried out best in the community whereas didactic teaching sessions consisting of lecture can formally be carried out at the medical center. Of course some of the latter can be introduced with the Physicians-in-Residence Program. I was told by many of the men when I left that they enjoyed the session very much and some of the points brought out were entirely new and valuable to them. I felt that the management of some of the patients might be improved as a result of our ward rounds and suggestions that were made.

Sincerely yours,

Leon Goldman

Leon Goldman, M.D.
Professor of Surgery

LG:am

REPORT ON PHYSICIANS-IN-RESIDENCE PROGRAM

Enloe Memorial Hospital, Chico
Harold I. Griffeath, M.D.
October 29-31, 1968
CONFIDENTIAL

I'm making some observations about the program sponsored by Continuing Education at Enloe Memorial Hospital and other hospitals in the region. There are several questions listed here. First of all the level of practice in the community hospital at Enloe. It seemed to me that it was at a very high level, unusually high for an outlying hospital of approximately 100 beds. At the Butte County Hospital in Oroville, it was certainly much lower in level and this is largely because they're having a hard time in finding full-time physicians to work there. The people that they have are somewhat limited in their background and competence. The head physician, for example, is a retired pediatrician, and yet has to do pretty much of everything throughout the hospital. They are trying to cover nights and weekends with moonlighters and these include doctors coming from as far away as Canada to cover a weekend, for which they pay $400 to have some weekend coverage of the hospital.

The hospital in Willowsseemed to be quite good as far as level of practice, with mainly general practitioners involved. The next question is weaknesses as far as practice; I've already commented on some of the problems at the County Hospital. Another weakness,it seemed to me,in Chico is the feud between the two hospitals in town. The community probably should have only one hospital. A dissident group of physicians broke away from the Enloe hospital and formed their own hospital, and now they have two growing hospitals in town with no real plan for any joint care of patients in the community. Apparently the relationship between the two hospitals is somewhat better than it used to be but still quite strained. This means for example, that there would be no possible consideration of using Enloe's excellent new coronary care unit for care of coronary patients in the area.

The other hospital will set up its own coronary care unit which will represent a duplication. This is true even though most all of the doctors in town are on the staffs of both hospitals. Another problem referred to by some of the physicians I visited with was that there tends to be some reluctance on the part of the generalists in town to use consultants in the treating of acute myocardial infarctions. Apparently the use of consultation by the several well-trained interns in town is quite limited. It occurs usually when there is some very major problem rather than as frequently as it probably should occur. I did discuss this rather frankly with the general practitioners. I don't know if it will make any change in the pattern in the community. As far as strengths are concerned, I have already mentioned that Enloe has a remarkably impressive coronary care unit. Its been in operation with tremendous support from the nursing administration, from the administrator of the hospital and from the staff, and a very competent director. I think that their coronary care unit is as good as any hospital its size in the state. I was also impressed with some of the general practitioners I met who are unusually knowledgeable and they seem to be very interested in continuing education. Most of them are relatively young, and I think are practicing at a level much higher than many generalists even here in the city. They have almost every speciality represented in Chico; the only exception is that they do not have a neurosurgeon. They badly need a neurosurgeon and they're trying to find one, because if they have patients (of which they have a good many) from automobile accidents being on the main highway that need neurosurgical care, they have to then send them a long distance to Redding or Sacramento. They are looking hard for a neurosurgeon and trying to attract them to Chico. There seems to be a fair amount of referral, expecially to the speciality such as eye and ENT. Most of the generalists seem to tend to do a fair amount of surgery themselves, and do most of their OB and GYN work and most of their seriously ill medical problems tend to be handled largely by the generalists without too much use of internists or general surgeons in town. The referral seems to be a little easier for the sub-specialists like the orthopedic surgeons or the eye-men or ENT-men. The next question is to state problem areas in the community. I've already mentioned some of the problems including the need for a neurosurgeon. They need as I see it to use their consultants more freely, especially in the area of newer concepts of coronary care. I've mentioned the problem of the County Hospital in terms of staffing. They also have the problem between the two hospitals. This is even a broader problem in that the town of Paradise, which is only 10 miles away, also has a hospital. Here again, the feeling is that this hospital should have its own coronary care unit. I think one of the needs of the community will be to try to define certain speciality facilities that might be developed in one hospital with the other hospital having a different speciality service it might offer to the community; rather than the tendency of each little hospital trying to do everything.

Use of ancillary services is the next question here, and I'm not entirely sure what that means. I'm really not familiar with the Cobalt unit because it's a little bit out of my area of competence. We were really not focusing in that area. It's the only one for a large region, and I assume that it will probably be used, but I don't really know. Their coronary care unit is being used more than they had anticipated. They added up the number of myocardial infarc patients for their hospital before developing their five bed unit, and based on the number of coronaries they were treating before they opened their unit, five beds would be too many. However, they find that they are getting myocardial infarc patients from a rather wide area because they have the only established going coronary care unit in the area so that people are coming all the way from Colusa to be treated in this unit. They seem to have a very good nursing service. They have an in-service nurse educator, which most small hospitals don't have. They really seem to have a good esprit de corps among the administration nursing service and the physicians. The administrator has been there a relatively short time; a man by the name of James Sweeney. I think he's been there perhaps a year or a year and a half, if that long. He formerly was at UC and also at Pacific Medical Center when it was called Presbyterian. He's an exceedingly pleasant person, who was very cordial; an excellent host during my stay there, and he seems to be well liked by people. He had the situation of coming into a hospital where the Superintendent of Nurses had been there for 18 years. I imagine that it must create some problems to have a very strong nursing director of 18 years seniority and then to come in as a younger hospital administrator. I didn't see any evidence of any problem in this regard. The whole place just seemed to be one with a good spirit and I heard no evidence of any real conflict of any of the various segments of the hospital. The only conflict I heard was sniping about the other hospital in town. Although I also heard comments that perhaps the other hospital having been formed and developed was a strong influence in seeing that Enloe corrected some of its short comings. One of the reasons that it seems to be moving forward so well is that it has some competition. Perhaps it isn't all bad that they have two hospitals.

Recommendations as to the method by which the Medical Center can best meet the educational needs of the physician in the community. The physicians really seem to like this business of having somebody come to them rather then their having to come down to the Medical Center. This was said over and over again, "isn't it good that 40 or 50 of us can have an educational experience by having one person travel, rather than having many of us go down to the city." They really seemed to like this. I think if it's focused on some particular need or area of concern in the community such as coronary care units are at the moment, the turn out could be expected to be as good again. I think it would be important that they wanted some particular segment of medicine covered in this way rather than a "shotgun" approach. I think that the other thing that made this work fairly well was that they had done most of the local planning and making the decisions as to what would be discussed. Dr. Bernadett who was the person who really planned the program and was my host for the whole time, is a very likable young generalist who seems to me to be unusually competent. He really made my three days up there easy and very pleasant. I think that I was lucky in that I doubt that most people doing something like this would have anyone quite as conscientious and as likable as Dr. Bernadett.

The three-day period, I think, was not too long. Partly because I had spoken at the County hospital in Oroville which was to one group, and then to the Medical Society which involved people from a very broad area. Then two talks to physicians at Enloe, and then to a different hospital in the area in Willows, than I had three talks with nurses. So that it would take three days to cover several hospitals in an adjacent area and to cover both physicians and nurses. I think any more than three days would be too long. For example, Dr. Bernadett had to really take a significant amount of time out of his schedule to attend several of the meetings. I think in terms of the local people who have to do the planning, three days is plenty. In terms of the person going up, it is plenty.

I think that if it were all held in one hospital, the number of people that participated would be less, because the session at Oroville was an expansion of a weekly session they hold there. There were some people from that area who would not and could not have gone to Enloe if it had been held there. The same is true in Willows, it's about 40 or 50 miles away. There was one man from Willows who went up to Enloe. Probably there wouldn't have been more than one or two, but by stopping off at Willows on the return trip and spending a half day there. Most all of the physicians on their staff plus most all of their nurses were involved, so I think as soon as you try to concentrate it all in one hospital, you might get all the people in that hospital, but then you are going to have a very sharp drop off of the people whose loyalties are mainly in other hospitals or who are located some distance away. Whereas, in a town that has two hospitals but the same medical staff, such as Chico, it isn't necessary to go to both of the hospitals in town because you could get all the same doctors. The same thing is true at Marysville Yuba City. They have two hospitals, but they have identical staff. Even if you want to talk to the nurses, they can go from one hospital to the other. As soon as you get a hospital that's 15-40 miles away, you're going to have to go there or not have very much contact with the people who practice there.

Would you be willing to go back a second year? I certainly would if I have enough advance notice and can fit it into my schedule. I would hope that I could, because it was enjoyable. I would like really to see how they're doing a year later in some of the areas where they have problems in relation to coronary care. Especially in some of the outlying hospitals. The fact that Enloe has such a good unit, has resulted in especially keen interest in this region for similar facilities in all the other little hospitals around. They can't all have a unit like Enloe, because they're just aren't that many beds needed. They could have better intensive care facilities. All the hospitals need better facilities for coronary care. This involves a lot of nurses training. It involves, in some areas manpower problems. Some of the hospitals, especially such as the one that's right out of Yuba City and also the County hospital have very few registered nurses. They're so limited in their manpower problems, that to try to have ideal coronary care is a tremendous problem. The solution for an area like this may very well be not a coronary care facility in every little hospital, but several good ones scattered about with a better ambulance facility for moving people. This runs smack into the desire of every little community to have its own hospital and to keep its patients home. One could sit down and make a very nice scheme of things, but if you don't really know the local situation, you don't know how impractical your scheme might be. I don't really see that the hospitals are going to join forces in coronary care. Each one is going to develop some sort of special care for its coronary patients. The thing I'd like to see is how inventive they are in adapting their need for better coronary care facilities to their local situation, manpower and other problems. Each one has sort of a unique problem in solving it.

I wanted to say finally, that some of the comments I've made are purely impressions from having a very limited opportunity to have any kind of in-depth understanding of some of the hospitals and people. I hope they're taken in this context, both in terms of confidential and also I could really be quite wrong in some of my impressions, because they're only impressions.

REPORT ON PHYSICIANS-IN-RESIDENCE PROGRAM

Watsonville Community, Watsonville
December 14, 1968
Moses Grossman, M.D.

CONFIDENTIAL

Level of Practice in the Community Hospital: I was there only about six hours, and it is really unfair for me to make a judgment in this regard. In some ways I was really impressed by many of the things they are doing. But in the area of premature nursing particulary, I was impressed that they are behind.

Ways the Medical Center Can Meet the Educational Needs of the Physicians: They need to do two things; one is to make us realize what their problems are. They feel we are teaching people a little bit abstractly. They informed me when I arrived, they didn't feel that I was there necessarily to teach them something. They were going to show me what community medicine was like. Here we sit on top of Parnassus Hill and train people for practicing in a University hospital, most of the country doesn't practice in a university. They have an excellent lab, I was quite impressed by that. They would like more of an opportunity to send some students down, and I've already looked into that since I've been back. Then they want to resolve some Regional Medical problems. I think having me there provided them with an authoritive link with some university resource. Fundamentally, they need that kind of link. If their contacts suggest they do through this program, they will have the chance to have people come down and tell them what they need stressing on, and the university could or could not meet them. They need to feel that they are important, and not sitting there by themselves.

There are not a lot of doctors there, and three days is a large piece of time, for the number of people that are actually there. I think I'd go to some other place that has more people. I happen to be a pediatrician and the day I was there, they didn't have a single pediatric patient in the hospital. Not one other than the nursery. There were three or four babies in the nursery. They had one or two problems in infectious disease but not many. Dr. Leonards and I discussed them. From the point of view of being there for three days, I honestly think that because of my specialty, it would be a waste of my time. I would be willing to go down again for one day, but three days is too long.

I went to Sonoma, to Santa Rosa hospital on another program for one day. They have residents and a large staff and a ward full of children and I felt that I could have spent another day. I didn't have this feeling at Watsonville at all.

REPORT ON PHY[illegible]ENCE PROGRAM

N.T. Enloe Memorial Hospital, Chico
January 21-23, 1969
J.H. Karam, M.D.

CONFIDENTIAL

Introduction: Chico is a warm, friendly community serving an area containing 50,000 people. There were two community hospitals, both of which were well-equipped and modern in most respects. The 120 physicians included 30 specialists, representing most of the major specialties except neurosurgery.

My program consisted of a morning visit to the near County hospital at Oroville, California to discuss a series of problem cases selected by the medical staff, and an afternoon program with physicians of Chico and surrounding areas for discussion of common endocrine-metabolic diseases and their management.

A morning was devoted to nurses and their problems in the bedside care of diabetic patients, and another afternoon session was used to present practical considerations in the care of obesity and diabetes directed toward general practitioners of the area. The remaining time consisted of a tour of the hospitals conducted by my host, wherein I visited Intensive Care Units in each of the two hospitals, the library, medical records office, the wards and private rooms, the Cobalt Unit, laboratories and surgical areas. Two recent deaths were reviewed as to their management and diagnosis, and I had the opportunity to randomly select some medical records for review at the suggestion of my host.

Level of Practice in the Community Hospital: The care seemed to be satisfactory in most areas, although my visit was too short for making a true evaluation. I was impressed with the fact that with wide scale hospitalization and insurance programs, there was hardly a section of the population which could not affort the hospitalization,

PHYSICIANS-IN-RESIDENCE

or diagnostic tests needed to provide adequate medical care. Also, laboratory facilities by centers such as Bio Science which are readily available by mail permit access of dependable diagnostic tests to all outlying areas such as Chico. The medical personnel seemed dedicated, hard-working and were stimulated by the competition to keep up with current medical knowledge as much as possible.

Weaknesses as far as Practice: Sometimes it seemed the competition was carried too far, and there was a tendency of certain practitioners to fail to refer cases which may obviously have been better cared for by a specialist in a certain field. Many of the busy practitioners in the area have had to rely for information on detail men of various pharmaceutical companies and as a result were often unable to discriminate properly in the selection of drugs for management of some problems which I was particularly cognizant of--such as Diabetes and Obesity.

One area in which my arrival was timely was for discussion of the hazards of multi-colored "rainbow pills" for the shot-gun treatment of obesity. These were being widely detailed in the city and I emphasized their hazards and the many recent reports of death due to their use.

Strengths as far as Practice: The physicians have had to rely on themselves and their resources to solve problems when no special help was immediately available, and they have evolved a particular resourcefulness in finding solutions-exemplifying the western pioneering spirit.

There seemed to be a realization of the need for continuing medical education as evidenced by their very impressive turn out for the Physicians-In-Residence program despite their busy practices.

Their dedication to their patients was quite impressive. For example, my host was in constant communication by radio in his car, as well as by portable radio around his neck when horseback riding, and he showed great reliability in responding to patient needs much to the inconvenience of any attempted recreational plans.

Areas of Potential Improvement: A. Library facilities are quite limited; however, at present a program is underway to utilize Chico State College as a central medical library repository, wherein the Medical Society will supply current journals and textbooks for use by both the college and the Medical Society. B. Clinical Care in the hospitals was hard to evaluate in the short time I was there. I feel if they could qualify for approval of a general practice residency training program--it would be an incentive to maintain good clinical care in order to keep their accreditation, and at the same time, have responsibility for teaching which is an excellent incentive for maintaining an interest in current medical advances. Administratively, two separate hospitals have been set-up resulting in duplication of facilities. While this has certain advantages--in that health competition has resulted in each striving for betterment of their Intensive Care Units, laboratories, etc., there might be a good case for centralizing "Intensive Care' in one hospital and emphasizing another special area of care in the other hospital, in order to provide maximum efficiency with their limited resources. However, resolution of this problem requires more details than I had available during my short visit in Chico. C. The community itself is a growing, relatively wealthy community which takes pride in its State College and its scenic advantages. Maintaining a city park that is probably the largest in the County (14 miles in length), they feel it's a financial burden for a municipality that might be better handled by the County or State. This might permit diversion of funds for local needs possibly in the areas of improving health care facilities, and the community at present is working toward this end. D. The two hospitals are justifiably proud of their intensive care units which are equipped with the most modern facilities. Attempts are being made to staff them with personnel adequately trained for proper use of this equipment and while this has not been satisfactorily accomplished as yet, steps are being made in that direction. They physicians also realize their limitations in use of some of this specialized equipment and are very interested in further training in these areas. E. As mentioned earlier, the referral service could be improved upon. Specialists are available in most fields and patient care would benefit from less reluctance on the part of physicians to refer cases for fear of losing the patient to the specialist. Perhaps, a prompter return of patients to the referring doctor by the specialist would also improve the system and increase referrals of problem cases.

Ways the Medical Center can Meet the Educational Needs of the Physician and Community: The Physicians-In-Residence Program is an excellent *adjunct* to radio programs, closed circuit T.V., and post-graduate medical courses at the Medical Center. Perhaps specialty-residents in their final months of training could afford more time, so that four weeks in residence in the areas hospitals might provide better communication of recent medical advances to the practicing physician in fields of surgery, pediatrics, internal medicine, etc.

I would emphasize that each community has different problems regarding their needs and every approach to meeting these needs must be highly individualized--and is probably best expressed by local medical societies on their community leaders.

In conclusion, this was an enriching experience for me personally. I have become aware of many of the problems of medical practice in outlying communities which will be a help in my teaching and training of students and house staff here at the University.

Dr. Huitt, the Chairman of the Physicians-In-Residence Program in Chico, was a most gracious host. He has mobilized the resources of his medical society to cooperate fully with this program and is a fine example of a conscientious, dependable, resourceful pracitioner of medicine with a keen interest in improving his own medical knowledge.

REPORT ON PHYSICIANS-IN-RESIDENCE PROGRAM

Washoe Medical Center, Reno
January 8-10, 1969
Gary Kardos, M.D.

CONFIDENTIAL

Level of Practice in the Community hospital: The level of practice was surprisingly good, this is especially true of the younger men who are there. It seems that they are calling people from all over. They had one younger fellow who just finished at male clinic that came out. He seems fairly confident. The younger internists I met all seemed to be reasonably confident, and hard working. At one evening conference there were about 45 people there, and the other times, a dozen and a half.

Weakness and Strengths of Practice: The weaknesses are in any place where there is no university affiliation and no teaching program. There are certain things you do when there is no house staff. I think this is true of anyplace that you would go to where there is no house staff. Their strenghts are that there are a fair number of younger physicians. The chief of medicine is a young fellow in his thirties. Also their Director of Medical Education, Dr. Roberts is maybe forty. Most of them have a sub-specialty. Cardiology is probably the predominant one, or gastrointerology. There are only so many people that you can pull for immediate consultations. The choice is not large like in San Francisco. That is by virtue of the local. They have plans for expanding to 750 beds. They are starting construction soon. Their State legislature gave them approval for phase I of setting up a medical school in Nevada, in Reno.

Areas of Potential Improvement: Probably the lab is the strongest place. They work in a small place, and things take time to get things done.

PHYSICIANS-IN-RESIDENCE

A lot of their facilities are going to get changed now that they are going to build a new hospital complex. It should be completed in 1972. It looks like a very nice plan.

Improvement of Medical Care, Clinically and Administratively: Clinically, I think that if they do develop the medical school there, I think that this will be the greatest boost for them. The more outside people who come in who actually see patients with them, in terms of differences of opinion, approaches, etc. The community has grown from 75,000 to over 100,000, in Reno. They service a large area. There aren't any problem areas in Reno.

Use of Ancillary Services: They seem to be on par with most other hospitals. They refer to Sacramento and some to Salt Lake City, Utah.

Ways the Medical Center can Meet the Educational Needs of the Physicians: By finding out just what they want and trying to provide it can be of help. Where do they think their lacking, and need help? If you could get people more often to go up, they might be able to tolerate it. Three days is sufficient. More than that, they would get tired of you. What you're doing is you are sending up somebody with certain strengths and that's the area he's involved in; surgery, obstetrics and all the other specialties.

249

SAN FRANCISCO MEDICAL CENTER: SCHOOL OF MEDICINE
DEPARTMENT OF ANESTHE

TO: Dr. Seymour Farber and Miss Virginia Finley
Continuing Education in Health Sciences

FROM: Dr. Joseph Lee, Director, Intensive Care Unit, San Francisco
General Hospital, and Assistant Professor of Anesthesiology

RE: A brief report on the Physicians-in-Residence Program at Memorial
Hospital, Redding, California on January 14-15, 1969.

The Memorial Hospital is a 135 bed hospital, very adequately equipped, which serves the whole of Northern California and Southern Oregon. The hospital has an excellent clinical laboratory department under the supervision of two highly qualified Pathologists. Many enzymatic tests and radio-isotope studies for complicated diagnostic problems are done right in the hospital. By so doing, there has been a significant saving in time and money. The Anesthesiology Department is very active in pre- and post-operative respiratory care and in the direction of the Inhalation Therapy Department, in addition to its busy operating room duties. The Inhalation Therapy Department has a full-time staff of four and provides excellent oxygen therapy service throughout the hospital. The present Intensive Care Unit is extremely crowded and lacks cardiopulmonary monitoring equipment for extremely ill patients. Space, better equipment, and more trained nurses are needed for the quite active 5-6 bed ICU. The well established Neurosurgery Department attracts patients from all over Northern California, Oregon, and Nevada, and the types of interesting cases keep the ICU very active. The Emergency Room is well equipped to handle any major, acute emergency. The hospital is operating efficiently under a balanced administrative and nursing staff.

The attending physicians are all extremely interested in Continuing Education. The attendance for the clinical luncheons, lecture, and general discussion were excellent. There were many questions concerning problems in acute medicine, cardiopulmonary disease, shock, care of the comatose patient, respiratory care, pulmonary physiology, and the use of blood gases and pulmonary function in clinical medicine which came up in the general discussion and on ward rounds. There is a need for a qualified chest internist and cardiologist in the hospital and in the community. The Newborn and Pediatrics Department are rather weak, mainly due to the lack of pediatricians in the City of Redding (there are only two pediatricians in the city at present). These are the areas of potential improvement.

My visit to Redding imparted many facts and ideas on acute medicine and the management of critically ill patients. I strongly feel that such Continuing Education programs not only add new knowledges to the physicians in the community, but also stimulates their thinking toward the continuing growth in medical care. It also keeps the physicians up to date with what we are doing in the various medical specialties at the Medical Center and lets them know what we can offer them in the way of referral services. I highly recommend that the Medical Center should send a team of physicians or nursing and administrative staff of various specialties to these peripheral hospitals more frequently. Since the Memorial Hospital is planning to build a new Intensive Care Unit, my session spent with the administrative and the architectural staff on the planning of the new ICU was extremely valuable and essential - since the medical and nursing personnel are dealing with the physical set-up, space, equipment, etcetera, on a daily basis.

Joseph Lee M.D.

Joseph Lee, M.D., F.R.C.P. (C)
Assistant Clinical Professor of Anesthesiology
Director, Intensive Care Unit
Director, Inhalation Therapy Department
San Francisco General Hospital

JL:sf

251

REPORT ON PHYSICIANS-IN-RESIDENCE PROGRAM

Mendocino County Hospital, Ukiah
October 2-4, 1968
Frank Leeds, M.D.

CONFIDENTIAL

Level of Practice in the Community hospital: I was at the General and the Community hospital. Both of the meetings were held at the General hospital or the County hospital. This is primarily a psychiatric hospital although there's an active medical and surgical service. Most of the patients came from the Community hospital in Ukiah. The man in charge of surgery there is a well prepared general surgeon. The consultants they have are also advanced. Just judging on that superficially I would say it was probably adequate. Going back to the Community hospital; this was quite good. I made rounds at Hillside and saw arteriorgrams; and saw patients with the physicians. I thought the level of practice was quite satisfactory. They have consultations from the internists. They had fairly adequate X-rays. They are a little short on the most advanced arteriorgraphic techniques, but then you would hardly expect it in that sort of community. The men were pretty good; they had reasonably satisfactory arteriorgrams. The men taking care of the patients were, I thought, doing very well.

The Strengths and Weaknesses of Practice: The strengths were that they do have beside the basic corps of general practitioners; they do have a good group of Board men who are interested. They're behind this training course there; the ones who set it up. Most Board men in general surgery and a good group of internists, and the radiologists I thought were very good. The weak points from my standpoint would be so many of the general practitioners who probably should have been there were not there. The men who really were there, were basically the specialists who are already better trained, at least better trained in one field. They're the ones who are interested and come to these meetings. A lot of the general practitioners who probably should have been there were not there. The men who come are generally the ones who seem to be interested. There are deficiencies in technical things like arteriorgrams which they're trying to remedy, within the limits of the hospital. I think they would do better; I mentioned this to the physicians there; they've got two community hospitals, sort of competing. I think if they could just get together. There are three hospitals in Ukiah; there are two community hospitals and then the big State hospital. They're full, but they could cooperate better. For example one of them could have all the arteriorgraphic equipment and maybe the other hospital could have something else. Two small hospitals competing; this I thought was one of the weaknesses. The men they drew in came all the way from Ft. Bragg. One man came regular everyday from Ft. Bragg. I didn't go over to Ft. Bragg, I stayed in Ukiah the whole time. Several men came from Lake County, they were quite regular in coming over.

Areas of Potential Improvement: They have access to blood. They work with Santa Rosa, and apparently get adequate amount of blood. They see a fair amount of trauma; you know they're right on the freeway. They get a fair amount of car accidents. They're in a sort of logging community, there is some logging close by, so they get some of those injuries. They seem to be well equipped to handle trauma, and they have adequate blood. Most of mine would be the extension of their technique. They apparently don't try to bite off more than they can chew. They still refer a lot of cases to the City and Santa Rosa. They can handle the traumatic vascular cases, and do it fairly adequately. Their links are with

253

San Francisco and with Santa Rosa. There is a good group of physicians in Santa Rosa, so they refer quite a bit there.

Improvement of Medical Care in the hospital; Clinical and Administrative:

Administratively, the main problem was this competition of two relatively small hospitals. They both do need intensive care units. One hospital already had a good intensive care, it seemed quite nice; a five-unit affair. Speaking to them, I realized there is competition for X-ray equipment, and they just don't have the money. The point is I guess they worry that the one hospital that got it would then get all the cases which is logical. There is some way they should divide up the cases between the two hospitals. One hospital would stress one thing, and the other hospital something else. They each would do better. Medically, I think they recognize their own weakness. They do come to the City. I know two of the surgeons I see quite regularly at vascular rounds. They come down and spend all day Wednesday for the medical rounds in the morning and then come to the vascular rounds in the afternoon. Again, these are specialists. I think this idea of having graduate, or post-graduate course in their own community appeals to more of them. It's easier for them to sort of interrupt their daily routine, and go to a local meeting than it is to pick up and leave completely the community. I know I've seen many post-graduate courses given here in San Francisco, and I've never seen this many from Ukiah at one time. I spoke to one of the general practitioners who was there everyday, and I said "how did you do it?" He said "I started at 7:00 am and made all my rounds," and he would stay at the meetings until 3:00. Then he said he would schedule his office from 3:00 to 7:00 p.m. This is the way he handled it, but he did not electric surgery.

That's the way they kept their schedules. I went over to the Community hospital, their private hospital; and made rounds. They picked up three private patients and showed me their charts and X-rays, and discussed treatment. Their charting is fair. The three cases I saw: one was a general practitioner and he had had an internist inconsultation. The internist had a good workup. That was really top-notch. His own personal workup was just a couple of lines. The other cases had just fair workup. Their post-operative notes were adequate, they weren't done daily. The complications were all kept and charted.

Problem Areas in the Community: Ukiah is rather a depressed area. When the sawmills close down, things can get rough up in that area. The question I should know is, what happens to the so-called destitute patients? I don't know the answer to that. So many of them are MediCare and MediCal. The young ones come up against unemployment; what their medical problems are, this I don't know. the answer to.

Use of Ancillary Services: They have a physio therapy department, but a good physio therapist doesn't need a big department. They have their lines of communication with Santa Rosa as far as blood and auxillary things like that. EEG's they send to Santa Rosa, and encephlograms.

Attitudes of the physicians: About eight years ago when I did the northern counties, Ukiah, Napa, Eureka and Auburn, basically the same group was there. I found them an interesting audience at that time. I've gone back once or twice at their own invitation to speak about different problems. The County Medical Society did not meet while I was there, and I did not address them. I have addressed them in the past. They were highly enthusiastic about this new program, the PIR program. They were highly enthusiastic with him.

PHYSICIANS-IN-RESIDENCE

They were delighted with what he had to offer. I found no problem with vocabulary. The basic group are internists and general surgeons, and one orthopedic surgeon. The smallest group that attended the meetings was about twenty, and the top was about thirty. Now out of these twenty, there about five Board surgeons. There was one Board orthopedist, and three or four Board or Board qualified internists. They were there almost every time. Out of that basic twenty to thirty you have eleven well trained Board or Board qualified people. There were also two radiologists. They were the ones who asked the most questions, they presented their cases, and the radiologist showed X-rays and then they would discuss the problem. They had a regular program, topic by topic for the three days. It wasn't just dry lectures. In the morning they had one or two patients they presented. Then in the afternoon they had a clinic which the various physicians brought problem patients, and we actually had patients there.

Ways the Medical Center can Meet the Educational Needs of the Physicians:

The basic thing is a way to send the men there. This format or some similar format. Talking to them, this appealed to them more than just getting up and coming to San Francisco. One physician took off a week from his practice and came down and followed me around for a week. This was very interesting. You do have to give a little because you have to take time to talk to them. If some of the people would be willing to do that, some would really like the invitation or to know that this is available. It might be one way of opening up the University where they can go with one man. I'm sure they all know they can come and make rounds; they like the personal attention. Remember those two surgeons I invited. I told them about grand-rounds on Wednesday. Since then, they've been coming

Cont. Frank H. [illegible], M.D.

PHYSICIANS-IN-RESIDENCE

down quite regularly. They do this at least once out of every two weeks. If you are able to send men from time to time in each field. I'm interested in the clinical field and these are problems these people are dealing with all the time. It could be that some of our more lab-oriented men, who are working in very technical fields get into vocabulary problems. This happens to the best of us. This is a much better way of trying to bring post-graduate work. The eternal problem is how do you get the men there who need it most?

REPORT ON PHYSICIANS-IN-RESIDENCE PROGRAM

Watsonville Community, Watsonville
December 12-13, 1968
Richard Leonards, M.D.

CONFIDENTIAL

Level of Practice in the Community hospital: It was very good. Most of the physicians, about twenty-five, are general practitioners. At one time, every member of the hospital staff attending the sessions with the possible exception of three at the most. It was 90% of all the doctors there. They were very interested and intelligent questions. I'm thinking of the level of practice in terms of the small community hospital and not the Medical Center.

Weaknesses and Strengths of Practice: The strenghths would have to do with the activity of the medical staff, which I felt these were interested people, and to me that's strange. The weaknesses have to do with general weaknesses of small hospitals, in that they cannot manage to have sophisticated monitoring equipment, and all of the sophisticated laboratory tests in every field to aid that hospital. There is difficulty in getting personnel, and I'm thinking of lab technicians that are sufficiently skilled in my particular area which is microbiology, to perform. They have one microbiologist, and he can't be there all the time. He's interested in his field, but his knowledge is somewhat limited. He needs to keep up.

Areas of Potential Improvement: Their lab technician who does their microbiology could be excused for a couple of weeks every year to attend a seminar; a workshop type seminar; in advances in microbiology. There should be some arrangement in a post-graduate level made for this type of education. I'm sure that things like this are going on some place. I don't know where they are right now. I offered to have this man come up to Children's Hospital to our own microbiology department for a week of on-the-job observation. I feel that this would be the strongest part in their infectious disease program. It's a fairly good, but old hospital. They're moving into a new physical structure in March of this year. It's a beautiful building. They don't have any large wards, and this cuts down on infection control problems in hospitals dramatically.

Improvement of Medical Care, Clinically and Administratively: There was one philosophical question I raised with them down there and that is; they cannot possibly expect to do everything. What they have is a certain amount of time, a certain of money and energy. They need to take those medical areas for development that are really give them the greatest return for their expenditure and time effort in money. I suggested that they didn't need a cobalt unit, this would simply not service enough patients and would be extremely expensive to operate. I think that even the small community hospital needs to have emergency resusitative equipment for a cardiac arrest and respiratory failure. Anyone that's going to be doing any surgery is going to run into cardiac arrest, and any community hospital is going to have miocardio infarction as one of the more common admissions. This is an area that they need to develop. I ran into a political problem which was very interesting to me. One of the more influential members of that hospital is an internist who had strong interest in radioactive isotopes. He was attempting to convince the medical board, the executive as well as the administrative boards, that they needed to put in a radioactive isotope monitoring devices so we could do scans. There's nothing wrong with radioactive isotope scans. I think that they are very, very valuable, but they don't warrant the same degree of emphasis as providing for intensive care unit with adequate cardiac monitoring , and respiratory assistance facilities.

259

PHYSICIANS-IN-RESIDENCE

Problem Areas in the Community: Watsonville is off the major highways, and it really is a small town. There's a small town feeling. This means that everyone knows each other, and there is a certain amount of that's going to go into it. I was favorably impressed with the attendance and the questions. I felt that the audience was alert and respectful. I enjoyed the experience.

Let me describe what we did. I was there at 8:00 a.m. and we had coffee and rolls, and I would give an hour of formalized lecture. I covered certain subjects. For the next three hours, I just walked around with them in the hospital seeing interesting cases and discussing aspects of infectious disease. Fundamentally our discussions were kept to infections, both the hospital and out-patient practices. At 12:30 p.m. I gave another formal lecture. I did this both days. I gave four lectures; the first two with respect to viral diseases. I presented a slide collection of viral exanthems, both the poxis and the exanthems, this took the first two lectures. The next day I talked first on out-patient bacteriology and common infections like sore throats and ear aches and bronchitis and urinary tract infections, a variety of things and what help we could get from the bacteriologist and office bacteriology. We made ward rounds and we went around and talked about certain patients and discussed the relationship to their current facility. Then I spent a couple of hours going over with a half a dozen doctors and the microbiologist, his technique for doing certain things. This is why I said he's eager and energetic and interested, but needs to have a place where he can go and catch up on techniques. There are a number of things which he could do for them that would be most helpful, that he's not doing or else that he's doing improperly, and not giving them the best answers. It's not a matter of his not being interested. The administration should come to grips with paying him for two weeks while he goes someplace to do this. I didn't get into their wound infection rate very much because the records were not really adequate in this regard, but from this discussion with them, they have not had any serious problem with this. As a rule in this area of post-operative infection the reason they don't have much of a problem is that they don't keep records and don't recognize it. I can't go into this any further with them at this point. This is a very complicated and involved issue.

Use of Ancillary Services: I talked with the radiologist and felt that he was interested and knowledgeable and the same of the pathologist, who seemed to have a pretty good grasp of what was going on. These people do go away for meetings and conventions. They do use their ancillary services to their ability and to the extent of the facilities they have.

They have a referral service, and identify with Stanford to a large degree because of its proxsemitry. They also refer to UC. The individual staff physicians have their own contacts. One doctor I talked to, it became apparent that most of his referral work went to Stanford. Another doctor I talked to stated that most of his referral work was coming up to San Francisco. I also had the feeling that these people did refer when they were in trouble, although in this respect very often one gets in trouble too fast to refer. They can take chronic diagnostic problems and refer them, but if they have the acute situation they keep it. The patient either gets their quality medical care, which I think is good for where they are.

Ways the Medical Center can Meet the Needs of the Physicians: I have some letters from a couple of physicians, saying that they felt that the format that I had with them was excellent and that they appreciated it. I didn't have any complaints, but I guess I wouldn't. I think that they need clinical presentation and clinical discussion rather than basic science. They come up to the hill for basic science lectures in a given subject. They appreciated the clinical management problems, just office type talk with the troubles you have with this antibiotic or that antibiotic on a personal conversation basis, rather than statistical analysis. I feel that they need someplace where the microbiologist can keep up. I have a feeling that this type of educational program would be good if it's not overdone. It's better suited to certain types of subjects than for others. I can't talk about anybody else's specialty, but I think infection is a good one. I don't know whether endocrinology would be one to go down as a separate topic or not. I don't think they can set up a comprehensive endocrinological lab, nor do I think they should. If they get into a severe endocrineproblem they should refer. Picking the types of subjects for discussion, they should be directed toward their bread and butter type of medical practice, not the rare diseases.

For me two days was plenty. I could certainly spread it for three days, since the type of discussions we did were not those that demanded exhaustive preparation or research beforehand. Most of it is a bull-session type of thing.

The lunches and breakfasts were organized and in-between they had a rough idea of what they wanted of me. I was free after 1:30 p.m., they didn't occupy the afternoon, which they could have if they had so desired. I appreciated the time, because after four hours of talking, you need it.

Report on PHYSICIANS-IN-RESIDENCE Program
Memorial Hospital at Exeter
May 13-15, 1968
Dr. Harold Lyons

CONFIDENTIAL

Dr. K: Judging from your own observation, what would you say about the level of practice in Exeter?

Dr. L: I think as far as the general level throughout the Valley goes, it's pretty good. I think it's as good as other places, the problem is one of record keeping and petty jealousies and failure to cover the hospital trustees so that they end up with a usable hospital.

Dr. K: All right, now, you pointed out to me the other day a lot of the weaknesses of the hospital, I wondered if you would just elaborate on that again. I'm sorry I didn't have my recorder on the other day.

Dr. L: Well, first of all they've got an excellent physical plant. They have an excellent X-Ray department with all sorts of equipment. I mean 100 mil. radium, a cobalt machine, 70 mil. of cobalt, and payment applicators for intercavitary use. They've got a beautiful setup there. Their surgery has some problem with the air conditioning and they leave the doors of the surgery open. They don't go through the hall, they go through the scrub room of the surgery to get into the doctors' dressing room, which means they go through the medical suite with their clothes on which is bad with the doors of the surgery open. They only have one room and they have no full time Anesthetist. There is only one board qualified Anesthetist around there, and he covers three or four towns and of course is not available most of the time. As far as their Obstetrical anesthesia is concerned, I guess it amounts to none. I didn't see any record except that they gave spinals but these weren't coded.

Dr. K: Not coded at all?

Dr. L: Not coded at all---the type of anesthesia-- the type of delivery. I mean the coding was exceedingly bad and one of their problems is that their total obstetrical load is too loaded to maintain around-the-clock staffing. They deliver about 25 babies a month there. In the total area or in the local area there are three hospitals seven or eight miles apart at Lindsay and Porterville. Lindsay would be the ideal one to do all the obstetrics and they could deliver enough babies to make it worth while to get a real service. Seven or eight miles one way or the other doesn't make any difference in there. Anyway, their blood setup was bad, they had to get it out of Fresno. I don't know---they said they could get it within an hour under ideal circumstances but I don't know how often the circumstances would be that ideal. With any traffic or anything they couldn't do it.

Dr. K: What would you say about the type of care from the point of view of the general practicioner doing deliveries and doing surgery?

Dr. L: Well, I got the idea that it probably wasn't so much the technique but the judgment that was the problem as far as the gynecological operations. In other words, what was done and what was written on the chart and what was coded didn't correlate at all. This is the sort of thing that would get them in serious trouble with the creditation people. If they lose their creditation, then all their insurances and everything else can't be collected by the hospital, which is letting the trustees down. Since they are making a point of publicly subscribing the money and raising the money themselves, and not taking in Federal aid, they should be covered in this particular area. Now, the departments have department heads but they don't function. When they have any problems with the given department, one of the problems is that they have alot of GPs in all the departments and the GPs immediately say, "well, the Specialist is picking on me," and they get the backing of the rest of the GPs in the area so that any disciplining or suggestions as what to do or what not to do comes from the president of the staff which is fine, as far as the immediate problems are concerned. There is no long range program, there is nobody---the president of the staff doesn't jack them up, doesn't make any serious demands on them. They make the demands but they are not apparently aware of the fact that what they say and what they do and what they record are three different things. The administrator was very charming and very helpful as far as the thing is concerned. They've got a   hospital. Ten of their rooms are obstetrical and twenty of them are convalescent care. It's a wealthy community---they've got a board man in Orthopedics, a board man in Internal Medicine, a board man in General Surgery, and a board man in Radiology and a Laboratory board man maintained. The laboratory seemed to be good. They do have a shortage of adequate nursing help, certainly at the administrator level of registered nurses. I mean, most of the work is apparently light and vocational and sometimes not the best from a registered nursing standpoint. It didn't seem to be followed through on what was ordered and what was done---that was the big problem.

Dr. K: Now, what do you think could be done to improve the hospital, number one clinically, and number two administratively?

Dr. L: Well, I think administratively the thing that has to be done is that the administrator has to be the one to do the cracking down to protect the hospital. The doctors aren't going to do it themselves. In other words, they lived this way all the years they've been there---up to fifty years---and times change and demands change and regulations change, but they don't want to change. I don't blame them, but still it's not fair to the people who are supporting the hospital to use the hospital and not protect it at the same time, and I think that the administrative part has to be demanded by the administrator. He can't throw it back to the doctors and say, "please yourself," because they can't do it. One thing is the factor of the Seventh Day Adventists versus the non Seventh Day Adventists, and this is a factor of the general practicioners which comprise a great majority of the doctors there versus the specialists. So that is also a problem. If they could get---I don't know---they need an Anesthetist for one thing, a full time, registered, board Anesthetist-----that's number one. They need a better blood setup, they need much better protection on their records, and they need to pull together as a unit to protect their hospital instead of protecting themselves or their religious affiliations.

Dr. K: All right, now this is administratively. How about clinically, and where do you see areas where it could be improved?

Dr. L: Well, they don't really have a clinic to speak of. The General Hospital has all private patients. There was no clinic as far as I could figure out. There is certain policing that has to be done from an obstetrical standpoint. I think I told you abou the one case that came in bleeding very heavily, and bled a grea deal at home, and they took her up and did a Cesarean Section which was prefectly alright for an abruption of the placenta. Her hemoglobin was never checked again and she went out in 48 hours. Forty-eight hours from the time of her surgery she left the hospital without even being seen by the doctors, dismissed over the phone, and this of course would be malpractice if anything happened to her because if she bled a great deal, and then went home and bled just a small amount, she might go into irreversible shock---you don't know where she stood when she left.

Dr. K: All right now, what about the major problems in the community, medical wise? What do they consist of mostly, judging from your vantage point?

Dr. L: Well, from my vantage point, the major problems are with records.

Dr. K: What about diseases?

Dr. L: They are an amazingly healthy bunch of people and they certainly---most of them---can well afford any care that they want, with the exception of seasonal workers who move along. They're not poor but they never like to pay for anything. They have no clinic facilities as such. Each doctor took it upon himself to try to save the patient money this way or that way, or send him home too early or something like that. That was an individual thing. I think one of the problems that will rock the community, and will probably cause a great deal of harm in the future, is this spying on the religious basis. I mean, each time the Loma Linda group brings in somebody, everybody else is mad. If the hospital administration brings somebody, all the GPs are mad. If the GPs bring in, or the general working staff brings in somebody, it works all right. If it's any of these other groups by themselves, it doesn't work. The rest of them are mad and they won't play. It's a childish sort of thing. The non Seventh Day Adventists feel like they are trying to load, or weight the staff with Seventh Day Adventists so they're going to buck everything and they all seem to resent anything that the Board of Trustees does---which isn't right because the Board of Trustees is furnishing them a damn nice little hospital, supporting it out of their own pockets and it seemed---my god, I don't know---they hold long meetings fairly frequently, they're really interested, and it's come right out of their pockets and there shouldn't be that antagonism between them.

Dr. K: How about your audience, did you have a good receptive audience?

Dr. L: Yes, can't complain about that. The problem was that they weren't set up for a Gynecologist and didn't have any gynecological surgery set up at all. I think it was done while I was there and it was a sterilization from a gynecological standpoint.

Dr. K: What about the use of ancillary services, and how good are they?

Dr. L: You mean the laboratories and X-Rays?

Dr. K: Yes.

Dr. L: They're excellent, very good.

Dr. K: But under staffed?

Dr. L: No, those two departments seemed to be all right---the Pathology and the Radiology. The nursing staff was the thing that was under staffed.

Dr. K: Now, what about the potential of referral and their actual use, do you think there was very much referral to the major centers, either UCLA or Loma Linda, or here?

Dr. L: Yes, I think the potential is tremendous. Yes, I think it is. Unusual diseases and so forth.

Dr. K: And there is no reluctance, and you didn't gather any reluctance on the part of the staff to refer if they found it was out of their area of competence?

Dr. L: No, I don't think so. They had some pretty good men in Fresno and their tendency to refer that far away is not very great. They are a little more likely to go to Southern California and they're below Fresno. They're really Southern California no matter how you look at it. Visalia, which is the closest town of any size, of course they have a hell of a problem---they've only got about 70 beds for five times the population. Each of these little towns draws from around 20,000. Exeter would be about 10,000. Lindsay would be 10,000; 20,000 to 25,000 for Porterville. So you've got 50,000 people in this one area. I think more than the doctors referring the patients, I think the patients frequently go on their own to other places because they have the money to do it.

Dr. K: What would you say in this trip was one of the most striking things, one of the most shocking or striking examples of poor medicine?

Dr. L: I think this thing with the obstetrical patient was the poorest of the bunch.

Dr. K: You mean when they discharged her?

Dr. L: Yes, 48 hours after. . . reading the chart, the description... this girl must have bled a great deal and the fact that her hematicrit was up, relatively at the time of surgery didn't mean a damn thing because had she been bleeding to death, the last drop would have been the same as the first drop, and there was no attempt to find out much she had lost through repeating this 24 to 48 hours later when this thing had equalized itself . . . and that was just it. Very bad, the doctor didn't even come to see her to dismiss her. Belli, or anybody, could have nailed anybody on that.

Dr. K: Alright now, you've given me suggestions for improving this, do you have any other suggestions that you might . . .

Dr. L: Well, I think they should reroute the thing so they can't walk through the surgery in their street clothes to get to the doctors' dressing room. They have an outside door, they ought to just close it, instead of drawing a line on the floor. I guess the bacteria can't cross that line! In a farm community, you always have a lot of cow manure and alot of fertilizer around. . . you know? And the fact they haven't had any major thing doesn't mean that they won't. They're just asking for it. A tendency for GPs to consult with their partners in their offices and so forth on hysterectomies done for prolapse, and they were doing supervaginal hysterectomies, and that isn't going to cure the prolapse. It's going to temporarily solve the problem and in a few years the thin is going to be back. It's a matter of judgment, but the technique I mean---they were fast and they moved right along---no unusual number of womb infections or anything. . . They didn't know what they were doing.

Dr. K: I'll be darned.

Dr. L: This is not unusual, I mean ~~in~~ the general scheme of things I think you could probably say this is true all through the Valley.

Dr. K: But you were, in the sense, somewhat taken aback by the type of practice were't you?

Dr. L: Well, I expected it, I mean I expected it to be different so I wasn't shocked or anything. I was just a little bit sorry that they were laying themselves wide open all the time and were apparently not aware of it, because the girl who went home so damned early after the Cesarean Section, massive hemorrhage and so forth---my god, if the hospital would have been sued, everybody would have been dragged into it. It wasn't just the doctor who took care of her because there are no rules as to what you have to do. In other words, you don't have to get a 24 or 48 hour hemoglobin on a postpartum patient, and the charting on the pregnancies was just impossible as far as figuring out what the hell went on. You don't know how they were delivered or what happened, or anything else. Frequently, their history and physicals were very meager, I mean on hysterectomies. Of course you see with a GP, seeing the patient in the office all the time, he has all the records---but that doesn't do the hospital any good if anything happens.

Dr. K: Right, right, that's right. Let me ask you this---I gather you have accomplished something. You made them aware of alot of their shortcomings, now do you think that this type of program--three days is too long, not long enough, or should we send someone down every four months. Or do you think we should send someone down more often?

Dr. L: Well, I think there should be a follow-up on it, and I think part of it should probably be more in the line of a general inspection which I went to when there wasn't anything else to do. Ward Evans had about 25 or 30 charts he wanted me to look through and I looked through.

Dr. K: He's a pretty nice guy.

Dr. L: Yes, and he's very competent, he does good work, his patients are well worked up, there's no problem, but this is just the way it is. If you've ever been out in the country, that's the way it always is.

. K: Alright, now, would you mind going back next year approximately at the same time?

Dr. L: Oh no, I'd like to go back and see what's changed. I think you're going to have to follow-up, a letter or something like that---you know, to explain what their problems are. I don't think they're malicious or vicious, they're just not aware of what's going on.

Dr. K: Not aware of the problems?

Dr. L: Yes, not aware of the problems that face them. For instance, if they come in with a spot, or check on their creditation or something, boy, they're going to be in trouble. I mean the nice laboratory and the competent Pathologist and the good X-ray thing isn't going to get them off the hook. They're just going to start going through those records, and they won't close them down but they'll lose their creditation. They'll turn the whole thing into a rest home or something.

Dr. K: Now, I've forgotten what you said about, because as you know in this program we send a Professor out every four months. Now, do you think this is adequate, or would be adequate?

Dr. L: Yes, I think so, it takes that long for the wheels to even turn. I mean, there's so much friction in various areas, something has to be done to jolly them up---getting them all to working together before they could do anything. Instead of fighting each other and each one being suspicious. Each group being suspicious of the other saying, "you did this and you did that," and this sort of thing you know.

Dr. K: Gee, you've given us some very valuable information, Dr. Lyons, and I want to thank you.

Dr. L: I think that, gee, that some sort of letter ought to be sent out to them to point out the dangers of the record situation and so forth. I mean they've got to be tightened up, it's got to match. The Pathological diagnosis has got to match with what it says on the front sheet. If they say they've got Endometriosis and the Pathologist says "no Endometriosis," you can't write it down, and Endometriosis may have been the excuse for the hysterectomy but probably wasn't necessary. For instance, the guys who were doing the most hysterectomies there hadn't had any training. They were "nine month wonders" during the war and went directly into practic and had no residency, no nothing and---Christ, technically a good joint-cutter. I mean, they make a good butcher's assistant. Surgically, their technique was all right, but their judgment was no good. In fact, they didn't know why in hell they were doing things. The gal bled too much, so they took her uterus out. The way I looked at it, two thirds of them could have been controlled hormonely. They were either in the pre-menopausal group with irregular bleeding, and things like that, and they had one patient that I saw for them---a gal who was obviously dying of an extensive recurrence of a cancer after radiation treatment, and hell, they were talking about opening her up again. I said, well hell, you can't do that.If this is really cancer, nothing you're going to do is---you're not going to do anything but kill her. Get a biopsy, and they had never seen a needle biopsy---didn't even know how to take one. Run a needle biopsy, and since she was terminal anyway, why not put her on Thorazine and keep her comfortable. They wanted to know about transfusing---leave her alone. Make her comfortable. She's going to die---you can't stop it. I mean, their intentions are real good, their knowledge is limited. I don't think that a single operation was done with bad intent, just bad judgment.

Dr. K: Well, this is the information we wanted to know, and I think it's most valuable. You've been most helpful. Thanks so much, I'll be talking with you again.

-. L: Right, we'll try it again whenever you're ready---I'll take it.

Report on PHYSICIANS-IN-RESIDENCE Program
General Hospital of Monterey County, Salinas
Mar McGregor
May 22-24, 1968

C O N F I D E N T I A L

Dr. Kimbrough: Would you say that your trip was successful or not?

Dr. McGregor: Well, yes and no, it was successful but the attendance was extremely poor. If we were looking at this as reaching a lot of doctors, it seemed as if their advertisement out into the community came so quickly, the talk came so quickly after the advertisement went out that most of the doctors called in and said.... we just can't make it, w're booked up, we just can't come, and as a result we only had the house staff of the County Hospital which was only about, six doctors at any one time and a total of probably twelve doctors heard more more or less what I was saying or part of what I was saying. Now, we had a lot of the nurses and a lot of the hospital personnel who came in, which meant that I was talking to a group of about twenty all the time.

Dr. Kimbrough: Oh, well that's good.

Dr. McGregor: And, it was enough of a group to make it interesting and it was a lively group. They asked lots of questions and were interested in what we had to say. The surgery was the first morning. I talked about burns from Galveston, Dr. Blocker Blocker and then we talked about burns for quite awhile. Then we held a live clinic in the afternoon; it went most of the time in the afternoon. After the live clinic, we saw about twenty patients, I guess. I think they got the most out of seeing the patients that they were having questions with rather than what I was telling them by slides and by talking. Then, we scheduled the next morning for patients. The next morning we operated on four patients and one was a removal of a tumor across the bridge of the nose with a skin graft. The other was a removal of a tumor way down in the inner canvas of the eyelid area, the turning of a flap down in that area. The other was a large tumor behind the ear and a rotation of a neck flap to cover the defect. Fourth, patient was a man who had a Gynical mastia, and they just wanted to know how I did it. They do them all the time down there. They seemed to enjoy the live clinic. Then we came back that next afternoon and I must have talked about four hours about tumors and showed slides and then about cosmetic surgery and showed slides and then about facial fractures and road trama and showed slides and so on. And, I got the impression that they enjoyed my coming down. I don't know if I'm being modest by saying that I don't know if I brought them a great deal, but you can get that more from them than you can from me.

Dr. K: All right, now let me ask you, judging from what you saw there, what would you say about the level of practice in Salinas?

Dr. M: Well, I can't because I only have a small segment to judge from and I am certainly not judging from the overall town at all, I am judging only from the practice in the County Hospital. I would say that their practice of Medicine and Surgery there was on a good County Hospital level, which, to me means, it's not as personable and probably not as high calibre as in a private practice, but, I may be wrong on that statement this is what it seemed to me.

Dr. K: All right, do you recall any areas of weakness that were particularly striking to you? Do you recall any areas where you would consider it on par with St. Francis, say?

Dr. M: Don, we're into an area that is real difficult for me to judge these men. I only see them for one day and I only see them on my level, I mean talking on my terms rather than what they're doing so I don't really have the basis on which to judge them. I think they are doing good work.

Dr. K: You do?

Dr. M: I think that they are in a type of practice where, let's take for instance this, there was a patient there with a, typical hippie who had an injury to the hand and an injury to the jaw. The jaw was well

277

treated no question about it and the hand had been, whether you should amputate or whether you should try to save the finger was waived and they tried to save the finger. I'm not sure that that was the best judgment but they tried to save the finger. I think eventually she is going to have a stiff finger. But this is a question of judgment and it was good judgment they exercised to try and save it. Their technique is good and they did everything well and now the patient is recovering. She is just taking off and going down to San Diego, so they are sending her down to the County Hospital in San Diego. So they are faced with patients, they just don't have as much control over them as you do in private practice. They drop in on you unexpectantly and you may never see them again, so it's very difficult to judge just what they're doing.

Dr. K: What about the areas of potential improvement clinically, could you give us some idea of that and also administratively, did you notice?

Dr. M: Administratively, things seemed to be handled very well, both from the administration of the hospital and the administration of the staff. Dr. Leonard seemed to have things well under control there and seemed to know what was going on and they all seemed to respect him and, no, I couldn't see anything wrong from an administrative stand point.

Dr. K: Clinically?

Dr. M: I just wouldn't be able to answer that.

Dr. K: All right. Now, judging from your brief stay would you point out, are there any major problem areas in the community?

Dr. M: Not that I noticed.

Dr. K: What about the use of ancillary services?

Dr. M: They were not using, well for instance, I asked them on a tumor do you have anyone here who does chemosurgery, I also asked them on another tumor if they had anyone who did injection of the different drugs, and both of those were no, they didn't have anyone down there who could do that, so, I have a feeling there must be someone in the community who is doing it but the County Hospital doesn't have access to them.

Dr. K: Now, what about the potentials of referral in their actual use, do you think this is used extensively there?

Dr. M: Do you mean potential of referrals out?

Dr. K: Out, yes.

Dr. M: To the people in town?

Dr. K: Yes, or up here.

Dr. M: I get the feeling that they are not anxious to let anything go to the people in town or to the big city.

Dr. K: They attempt to do all of this plastic work themselves?

Dr. M: If it's done yes, or else it's just not done, it's just let go.

Dr. K: Now, this is a big question here, do you have any suggestions for improving the hospital, all of the above which we talked about? What would be your suggestions?

Dr. M: At this moment I don't have any, I think, this being my first time out, I was probably more interested in giving them what I was trying to bring to them than I was in looking for these questions that you are asking. I think next time I can be a little more aware of what you want and maybe I can give you more intelligent answers.

Dr. K: All right, last question, would you go back down there one year from today?

Dr. M: Oh sure.

Dr. K: And then you'll get the same type of questions asked.

Dr. M: Sure, no question, I'd be happy to.

Dr. K: Okay.

Dr. M: Infact I'll go anywhere you want any time, you know that.

Dr. K: Did you have anything else you might like to add?

Dr. M: No, they were very hospitable, everything went fine.

SAN FRANCISCO MEDICAL CENTER: SCHOOL OF MEDICINE
DEPARTMENT OF ORTHOPAEDIC SURGERY

February 20, 1969

L. D. Kimbrough, M.D.
Continuing Education
570 U

Re: Trip to Washoe Medical Center
September, 1968

Dear Dr. Kimbrough:

I will attempt to answer your questions concerning the visit to Washoe Medical Center. My visit was almost entirely with the Orthopaedic Surgical Staff, although I did have the opportunity to meet many of the internists, some of the general surgeons, neurosurgeons, and radiologists. I cannot speak for the level of practice in the hospital in general; however, speaking as an orthopaedic surgeon and observing the level of care, technical ability and attitude of the orthopaedic practitioners, I feel that their level of practice is of the highest. I not only had the opportunity to make rounds with several of the orthopaedic surgeons, but I also entered into lengthy discussions concerning their cases. I at least saw their non-surgical cases treated excellently, observed their management of trauma, elective orthopaedics, scrub and surgery. I personally would have no hesitation in placing myself in the care of the orthopaedic staff at Washoe Medical Center.

I'm afraid that I didn't go into depth in many of the areas about which you have questions. The weaknesses of the Washoe Medical Center I cannot speak to. No complaints concerning the Center itself were voiced to me by the patients or by attending staff. The patient care facilities are excellent, surgical theaters are well-equipped, surgical nurses well-trained. The ancillary services provided by the radiology department as far as I could determine were excellent and their level of practice was superior. As far as the strengths of the Washoe Medical Center are concerned, I would think that it's excellent attending staff, nursing service and facilities speak for themselves. One area of improvement that might be considered would be to increase the size of their operating room; their surgical schedule is extremely busy and elective cases are scheduled well on into the day and until early evening.

What can be done to improve the medical care clinically and administratively is a difficult question to answer. I did have the opportunity to meet the hospital administrator and he seems to run a very efficient institution. I am sure that there is always room for improvement. I don't know of any problem areas in the community

UNIVERSITY OF CALIFORNIA—(Letterhead for interdepartmental use)

L. D. Kimbrough, M.D.
February 20, 1969

Page 2

itself. Use of ancillary services and referral services by the orthopaedic service is extensive. They did not, in my experience, hesitate to call upon consultants. Their interdepartmental consultations were frequent and freely given. It appears that in the Reno area, sufficient specialties are represented so that most medical problems can be well covered.

Before the question, "What methods can this Medical Center utilize to best meet the educational needs of the physicians and community at large?" can be answered, I think it is necessary to know in depth the deficiencies in the community. These I would think would have to be determined objectively. One method which appeals to me is the use of anonymous questionnaire examinations rather than the usual sampling question of "What deficiencies do you think there are in your community?", which is usually circulated to physicians.

Sincerely,

William R. Murray
William R. Murray, M.D.

WRM:jn

Report on PHYSICIANS-IN-RESIDENCE Program
General Hospital of Monterey County, Salinas

Dr. Raphael B. Reider

CONFIDENTIAL

Dr. Kimbrough: I wonder if you could give us an account of the strengths and weaknesses of the following: what do you think of the level of practice in Monterey County Hospital in Salinas?

Dr. Reider: Well, I was rather pleasantly surprised at the level of practice as I observed it in the hospital itself--that is--the practice as carried on patients who did not seem to have private physicians, but who under the care of the full time staff physicians, seem to get quite good care within the physical limitations of the facilities available. There are no restrictions in the kinds of diagnostic and treatment facilities which I suppose we'll go into a little later, but given this particular physical set up, I thought they got quite good care. With respect to the patients of private physicians who also use this hospital, I really didn't have much of a chance to observe. The patients who were presented to me for comment and diagnostic assistance were quite well worked up and the resident physicians there had a good knowledge of the cases and some very constructive ideas about what to do with them.

Dr. Kimbrough: Did you notice anything in particular which you considered weak in terms of the level of practice?

Dr. Reider: Well, they're terribly understaffed, so that every doctor had an enormous case load of very active patients. I think that the limitations of ability to follow adequately, closely, the patient's progress must be tremendous. On medicine, there were just two physicians really, covering the entire place, and it's a fairly large hospital. It's about 150 to 180 acute beds plus the fact that another one of the staff physicians was also solely responsible for the tuberculosis and chest section, which I believe was another 60 or 80 beds. Then there is a chronic section which had another 50 or 60 beds in it where this was sort of an extended care and chronic illness facility, which somehow had to be covered by the same people. This is certainly a weakness and there seems to be a perennial problem of attracting physicians to serve . . . . .

in this kind of a outlying community hospital. The doctors whom I did see, however, seemed to be interested and eager and quite competent in terms that they were knowledgeable of what a good level of practice should be and I think they tried to fulfill it as best as possible under these circumstances.

Dr. Kimbrough: The next question you've answered in part, and that's areas of potential improvement, clinically and administratively.

Dr. Reider: They've got to make more attractive offers to bring full time people down there who will devote their time to this kind of hospital practice. The thing is probably converting into a community type of hospital anyway, and although probably more than half of the patient population is migrant worker, farm workers who are quite transient and difficult to follow-up, I think that there would have to be an effort to attract people to come down there. And offering the prospect of a change to a community type of hospital where private patients can also be maintained at a high level of medical care should help a great deal. But of course, I think that they're going to have to offer other monetary and educational incentives. It's in the educational program where I feel the greatest deficiency existed there.

Dr. Kimbrough: How about the administrator? Is he in your judgment competent? Is he doing a good job or is he doing a mediocre job?

Dr. Reider: I think that this particular administrator, Dr. Leonard--these are confidential comments, I hope---was I think quite capable. He's a practicing surgeon, I mean he does his turn of covering the emergency wards at night and helps out in the OR's. He's not an antiquated, out-dated type of man that we sometimes find in an administrative posts like this. He seems quite energetic and very receptive to ideas for change. I think that he has been there for the last four or five years, I'm not sure. Apparently he represents a tremendous improvement over his predecessor. He feels, I think, rightly so, frustrated in terms of securing County monetary support for some of the things he wants to put through--programs and staffing problems--but by in large from what I could observe, and of course in the three days I was there, I'm sure he didn't confide in me his deepest concerns, but I think he's energetic. He goes to meetings, he participates in regional meetings. In fact one of the days I was there, he couldn't be with me because he was off on some administrators' project meeting. So I would say off hand that I found him also surprisingly progressive in his outlook, and willing to support any kind of modernization and upgrading of the standard of his hospital. He seemed to be well aware of the deficiencies and voiced some frustrations in his inability to overcome some of the problems.

Dr. Kimbrough: What about the major problem areas in the community, Dr. Reider?

Dr. Reider: Of the community itself, you mean?

Dr. Kimbrough: You mentioned the migrant farm workers.

Dr. Reider: Yes, the migrant farm workers are certainly an enormous problem. These people don't present themselves. There is a clinic, I should add, to the various other things that we mentioned of the various parts of the hospital. They also run a daily general medical and surgical clinic, and various speciality follow-up clinics on certain days. They see a large number of patients every day who just drop in--people who don't have a doctor--these people are brought from all over the place, all over the county, and many of them do not present themselves until a disease process is terribly far advanced and they literally cannot carry on anymore. The method of presentation makes treatment socially and medically quite difficult in that the patient may be brought to the clinic and whoever brought them will then disappear. The patient is seen and then put in the hospital and no one else is ever heard from again. There was one little girl, about a two and a half or three year old little girl, who had been referred there from another hospital farther south in the county--a smaller hospital--who was brought into that hospital after being in a gradual comatose state for approximately a month. The little child was simply brought in when she stopped eating and was then sent up to the Monterey hospital by the referring pediatrician who didn't even know where the parents were. This little child turned out to have tuberculous-meningites and was just too far gone, obviously was in opisthotonos and had a some cisternal or inter- . . . . .

cerebral block, and this child was undoubtedly going to die, because of purely poor level of recognition on the part of the population themselves, and on part of the parents or wherever this child was living, and kind of a non-caring attitude since there were probably ten or twelve other kids at home in a shack. So this is an enormous social problem that these people face. The elderly people are also brought to the doorstep of the hospital and left there, so this too happens. The younger people, the working people when they are discharged from the hospital, the chances of their ever appearing at a follow-up clinic visit are very remote because they simply move on to some other clime where the next job may happen to be. This is an almost an insuperable problem. The problem is of the doctor maintaining a close relationship with the patient and his illness from beginning to end, to its full resolution. It results in longer hospitalizations because they're reluctant to send a patient out when we normally would send a patient home for convalescence, assuming he's going to come back for some check ups or what have you. I think that especially in their types of problems and the chronic problems such as say tuberculosis, the average stay is something like four to five months in the hospital, because they just know that when they send these guys out they may never see them again. This is a tremendous limitation on the population and the education of the population in matters of recognition of medical symptomotology is just woefully inadequate. The people at the hospital did tell me that the visiting nurse association, people like the TB Association, the Cancer Society and all the various agencies do try to maintain daily contacts with these people when necessary. They will go out to the labor camps and visit the trailers every day to give medication if necessary, but even doing that may not be enough because the patients don't--they just move from one camp to another--nobody knows whither they have disappeared.

Dr. Kimbrough: What about the use of ancillary services, and their availability?

Dr. Reider: Well, I am not sure I can answer that too accurately. They told me that there's a visiting nurse association and the usual associated ancillary services are available to go into the homes, but I don't think that they have any coordinated home-care program there. As I said before, I think a lot of the patients of this particular hospital--this does not apply probably to the other smaller private community hospitals--but this particular hospital's population may be discharged to no particular address. The ancillary services, whatever they may be, aren't able to reach them. If the patients can come back to the follow-up clinic then the hospital provides a certain minimum of ancillary services on an out-patient basis.

Dr. Kimbrough: What about in the hospital itself, such things as x-ray, lab, and so on, how are they?

Dr. Reider: The laboratory seemed to be a very fine laboratory. It's fairly well equipped but not automated. I discussed this with the pathologist in charge--there is a full time pathologist who is there all the time--and he's got an assistant who's a chief technician. He was saying that the volume of work that they do wouldn't justify the investment of automated equipment. We got to talking about automated laboratories and so forth, and the fact that they could probably--I suggested that in a community like that or even in a county, that a central automated laboratory which might logically be centered at the largest hospital, which is this particular hospital, would seem to me a good way of handling laboratory work with a high degree of quality control and uniformity which go through the entire community. Well, apparently there a lot of private laboratories that are farming out work from the other small hospitals and from private doctors' offices. There are two or three other pathologists who are cutting up the rest of the work in the county. There is also nearby--the hospital happens to be on a plot of ground that is sort of a county civic center area, so the Department of Public Health building is an adjacent building. They have their own bacteriology laboratory there, and sometimes there's some reduplication of work that's done just within a hundred yards. So that struct me as a little bit inefficient. On the other hand, they were aware of a number of things which they were trying to remedy, we're still on the laboratory, so I will mention that they have recently purchased, and are planning to use, a special new kind of culture incubator with a high pressure CO_2 in order to get faster results by the Middlebrook Method of growing acid fast bacilli. This is--I forget what they call this particular piece of apparatus--I know it's expensive and fancy but it looked nice. It's nice that they're doing that, as far as I know, we don't even use that here in San Francisco. They have all the usual laboratory tests available but they don't have radioactive isotopes. In x-ray, they don't do scaning, they don't have the radio diagnostic methods in operation. I was told that some private offices do this if needed but they're associated either with the private hospitals or just with groups of other private physicians' groups. The things such as angiography are rather limited, they don't really do it. I believe he said they had an image amplifier but that was something new and it hadn't been used yet or wasn't hooked up. They're planning to get some TV amplification devices so that they can do some more sophisticated dye studies. It seemed to me that's really sort of in the future and that the diagnostic radiology there is not up to the best level, the most modern level. I guess that's the way it is in a lot of these small community hospitals. What else can I say about that. Certainly I guess they can do a couple of aortagrams, but they're not doing any heart studies or any intracerebral angiographic studies and certainly no intercardiac dye studies at all. I would say that radiology looked to me to be more or less a routine affair with not a great deal of special service available. I guess they do broncography. We expect that.

Dr. Kimbrough: You mean things like PT and OT? They have that?

Dr. Reider: They have that in the chronic wards, again probably understaffed. I wasn't able to assess that beyond the fact that they do have it and they have some kind of program. They do have a physical therapy department and they have an occupational therapy department.

Dr. Kimbrough: Now, the potential of referral and their actual use.

Dr. Reider: Well, what do you mean of referral?

Dr. Kimbrough: To major centers.

Dr. Reider: Well, I think that they do that. When they really get up against it, they send a lot of patients. I got the feeling anyway, that they send a lot of patients up to us here in San Francisco, they send a lot of patients up to Stanford at Palo Alto. Whether there's any real close tie-in or not, I am unable to say. I think the potential depends entirely on how far they're prepared to go down there with their diagnostic and treatment workouts. Say in surgery, they have a chest man there who can do lobectomies and open chest surgery, but there's no open heart surgery certainly they can do some arteriographs but nothing too extensive. I think their surgery is fairly limited to the routine things and I got the impression that they were referring a lot of the more difficult stuff out.

Dr. Kimbrough: What are the recommendations as to the methods by which the Medical Center of the University of California can best meet the educational needs of the physician in the community and the community hospital?

Dr. Reider: I think that this particular kind of program is a wonderful way of attempting to meet a major deficiency in areas with this kind of a medical set-up that I recently visited. As I intimated before in my remarks, the area of postgraduate medical education or on-going continuing education, if you will, in Salinas at least, seemed to me to be the most glaring deficiency in the total medical set-up there. It isn't because individuals there are not anxious for it, but there are probably a lot of complex factors that go into the reason why various local programs that they have tried to set up in the past have failed. I think that what we are doing here is only a beginning, and what I sensed was, that I was able to stimulate them to try to renew their efforts which had been flagging, to whip up some kind of formal program which would incorporate the various hospitals in the immediate area. So that they could at least have some weekly educational activity--be it rounds, or CPC's, or a formal lecture by an invited speaker, or just considering some of their own presentation of cases. The younger men there, of course, were the ones who attended my lectures and my sessions and our various conferences. I didn't see many older people. It was my feeling that these younger people that gave me the impression that they are capable of practicing a high grand of medicine. They are anxious to have an on-going program and I think they truly appreciated the fact of my being there and were very hospitable and were anxious to present their own patient problems, and quite attentive to the various programs that I was offering. I wonder how long this is going to go on. I was there, and I talked to them about maintaining an educational activity and I learned by their response that there are a number of major problems standing in the way of such a thing. It's difficult to find the time to hold some scheduled regular event, when the majority of the doctors would be free to attend or would be willing to give up whatever other activity they have. These physicians there are active in a number of different hospitals, and they have committee meetings, and thi that and the other thing. Coming to another meeting really doesn't sound too attractive. Even if it's for educational purposes. Now, I think really at the bottom of it though, that there is a certain amount of rivalry and a certain amount of rancor that exists.

Dr. Kimbrough: Now, the next question is, the sphere of influence. How do you think this is going?

Dr. Reider: I don't know whether it. . .we're talking about UC versus Stanford versus various institutions. . .I take it that's what you mean, institutional spheres of influence. I didn't get any special methods in that direction. I think they're happy to accept, or fall into, whatever sphere is open to them. As I said before to you, I feel that one of the crippling forces operating against the betterment of an educational program in that community is the, shall we say, the internessing rivalry. I think I sensed an undercurrent of really ill feeling that existed between the people in the private hospital, the small private hospital, that will never have an educational program, and the county hospital which should be the center of an educational program for the entire community. There is a certain amount of resentment, and there is a division of responsibility and a dichotomy or ambivilance on the part of even sincerely motivated physicians who feel that they have to contribute of their time toward these projects in both of these institutions. They're bogged down with committee meetings, as I said, and this, that and the other thing, and working in the clinic, and just serving time which tears them away more from their office. Now, does that answer the question more or less, or does that sort of skirt around it?

Dr. Kimbrough: Yes, yes that does. The other one is the existence of a Director of Medical Education, or an education committee. Could you speak a little about that, if indeed there is one.

Dr. Reider: I wasn't aware of anybody with that responsibility. There had been a Chief of Medicine whom I spoke to, who is no longer the Chief of Medicine because he just couldn't give any more time. He had tried to organize an educational program, and it had failed because people simply didn't come. They were discussing various problems of having evening meetings and scheduling them at different times. In terms of my meeting, they expressed a preference, and I think they did this without really thinking it through, that if we could send somebody down there every week for one day for three or four weeks in a row, it would be better than a concentrated three-day thing here where the same doctors couldn't come to the various sessions that we held. In other words, everytime I held a session, except for the staff doctors in the hospital who are there full time, the people from the outside. . .each time there was a different group of people who found it convenient to come. Now of course, the largest attendance I had was on a Saturday morning, when I suppose most people were a little free.

Dr. Kimbrough: Now, Dr. Wilson has added four others here. . .Direct consultation with Clinical Pathologists. . .do you have any comments?

Dr. Reider: Well, I spoke to the pathologist in charge of the hospital. Do you mean my direct consultation with him?

Dr. Kimbrough: Right.

Dr. Reider: I established a very nice relationship with him. We talked about the problems of the laboratory, that I elaborated before. I got the impression that he's

290

a knowledgeable and conscientious pathologist. They do very few autopsies. I'm also not sure that there is a great deal of consultation with the pathologist on the part of the doctors using the hospital. I don't know . . . that's just an offhand impression. I'm not sure if that's so or not, but in terms of formal rounds or formal sessions where they review microscopic slides and all that sort of thing, I don't think there's much of that.

Dr. Kimbrough: What about physicians seeing and discussing cases to develop some critical facility. I don't know exactly what that means, but . . .

Dr. Reider: Well I think that probably means some kind of a meeting where interesting cases are presented and discussed. I think that what I did in that line was probably the first they had had for many months, and that sort of thing. They were most anxious to do this. They arranged to get patients to come. . .people. . . who were not in the hospital. . .They had patients. . .come in for me to see and listen to their chests and so forth, from pretty far away. They hadn't had any sessions like this for awhile. Of course you know,as is usually the case, the doctors who are interested enough to take advantage of me, I think were doing alright anyway, without me. They wanted a confirmation or some seconding of their course of action. The turn-outs weren't all that great so I don't know to what extent they represented the usage of the hospital as a whole.

Dr. Kimbrough: Now the projective growth pattern of a particular speciality..that woul mean your particular speciality.

Dr. Reider: Yes. Well, as you may know, one of the things they were interested in getting from me was an impetus toward the development of an intensive coronary care-unit. Now they already have a kind of a recovery room and a general intensive care unit with some of the standard monitoring equipment and defibrillator devices. The nurses assured me that these are used, they do know how to use them. I didn't see any in use when I was there, but then I didn't see anybody who really had to have them. For pacemaker work, they usually send these patients up to Stanford or UC, anyway, and I saw some patients who had had pacemakers implanted but were not implanted at that facility. I think that they're interested and capable of developing a pretty good coronary care unit and they actually have a committment on the part of the powers that be in the county. They have already set aside an area in the hospital which he showed me, which will be a two-sided unit, in which one would be a general intensive care unit, and another would be a coronary care unit, with the special things needed for coronary care. . .namely quiet and carpeting and all that. They will probably have this in operation in about a year. . .this is what I was told. An intensive care and coronary care unit which will be two different areas but will be sort of adjacent to each other, which makes sense in a hospital like that. In terms of other aspects of growth in more sophisticated cardialogic, diagnostic techniques, for instance handling of congenial heart disease, doing cardiac catheterization, doing other kinds of physiologic studies. I don't think they're going to do that, I don't think they really need it. Maybe they do, I don't know what the demand is, frankly, but I think that this kind of a set-up is probably best relegated to the center that will be doing open-heart surgery. I certainly don't envisage open-heart surgery in this hospital. I could be wrong, maybe I'm being too conservative, but I really doubt it there's a need for it. I think that the open-heart surgery can well be handled by the major centers that are really geared to it. We shouldn't expect every little community hospital to offer most of that kind of thing. What would happen is that it would be a technique utilized very infrequently and consequently the people who would be doing it would not have the requisite experience and constant habit of using these kinds of facilities. It probably wouldn't be of high quality even if the people doing it were knowledgeable. This is the sort of thing that should be done every day,all the time by specialized groups.

Dr. Kimbrough: Then my last question is the potential for immediate improvement as compared to long-term in practice.

Dr. Reider: I don't know where to start. I really feel that the pursuit of the educational approach... that is trying to get the doctors. . .making them see a need for a good, solid, regular educational program is extremely important and would immediately result in an upgrading of medical care. I feel that they have a number of doctors in the area there. Now, I know a number of people myself in the Monterey-Carmel area which is really pretty close, who are awfully competent people, very knowledgeable, excellent specialists, who could have a great deal to offer the county group as a whole. Again, I'd like to say among the doctors I met there, a number of them could quite well hold their own in presentation of cases and discussion of disease processes with authority and conviction. What I'm saying is, there's a great deal of endogenous talent right there in the community which I don't feel is being used adequately. This goes right through all the various specialities that they have, surgery, chest surgery, ENT, pediatrics and so forth, and of course in medicine. I think that an intensive program organized and some how geared to achieve cooperation between the other hospital in the area. In Salinas itself, this means really one other hospital which is the Salinas Valley Memorial Hospital, a small hospital. There's a very small hospital, they didn't say very much about that. Their own doctors, I think, could run a good program and perhaps once a month they might have somebody from UC or Stanford or one of the universities, and every now and then have a. . .well I don't know how this is planned here. . . every three, four months or so; they should have a session such as the one I was privileged to give there.

Dr. Kimbrough: Every four months.

Dr. Reider: It's every four months? In a different speciality each time, is that right?

Dr. Kimbrough: Right. Now what we'd also would like is to ask you would you consider going back next year, and being as observant as you are, see if you notice any change during this period of time. Four other people will have gone there, meanwhile.

Dr. Reider: Yes, I think I would be quite happy to go down again, providing they don't regard me as some kind of a policeman. I think you have to feel them out too. I hope that you will get some kind of a feedback from them.

Dr. Kimbrough: We got an excellent letter from the director down there on your visit, and they were quite pleased. Well, what we do is. . .the idea is, how we approach this thing is . . . we tell them that "look we're not trying to evaluate you, we're just merely trying to evaluate our system of teaching, and if we're getting through." That changes things a little bit. They say "Oh, well, in that case." I say that if we can effectively change the type of practice that's done in community hospitals by this method, then we will have succeeded.

Dr. Reider: I think that if we can also bring them up here, their administrators or some of their full-time people, to possibly meet maybe with us and with people in other outlying community hospitals, and outline some of their common problems, so that they can be recognized. I think that when people live with certain problems they come to take them for granted, and maybe lose recognition of the problem. They sort of accept them and pretty soon they feel that it's not worth doing anything about them. So, this outside stimulus, I think, is very important. It's a little bit of an injection of fresh blood.

Dr. Kimbrough: Well, Dr. Reider, I'm telling you this is a most interesting report and I think this is going to. . .it's on the basis of reports like these that this program will be continued. I think you're most observant, and you are certainly an educator, and I want to thank you very much for your contribution. These recommendations will be submitted eventually in a big report to all of the hospitals. We submit your report back to Washington as you give it to us, then we write up this other report. We will submit it in a book form to all the hospital administrators, chiefs of staff, etc.

Dr. Reider: That's very good. I want to say that I really enjoyed myself tremendously there. I learned a lot about a kind of medicine that is quite alien to us who practice in the city with all the modern facilities at our fingertips. We really don't stop to think of the problems that these people have.

Dr. Reider: It's been a very interesting experience for me. I might say, that I not only would go back there, if I could work it, I would even go to some other places.

CHILDREN'S HOSPITAL
OF SAN FRANCISCO
A NON-PROFIT GENERAL HOSPITAL FOR ADULTS AND CHILDREN

February 11, 1969

BOARD OF DIRECTORS
Mrs. Wakefield Baker
Mrs. Ross W. Beales
Mrs. Starr Bruce
Mrs. Francis R. Burke, Jr.
Mrs. Ranieri di San Faustino
Mrs. George P. Egleston
Mrs. W. Parmer Fuller, Jr.
Mrs. Walter A. Haas, Jr.
Mrs. James Lowe Hall, Jr.
Mrs. Robert C. Harris
Mrs. Robert Homans
Mrs. Bruce Kelham
Mrs. Charles Kendrick
Mrs. Roger D. Lapham, Jr.
Mrs. Jesse W. Lilienthal
Mrs. Carl Livingston
Mrs. Dan London
Mrs. Charles F. Lowrey
Mrs. Edward H. MacKay, Jr.
Mrs. Robert A. Magowan
Mrs. James Mailliard
Mrs. Richard A. McLaren
Mrs. Lawrence V. Metcalf
Mrs. Otto N. Miller
Mrs. Robert Watt Miller
Mrs. Henry P. Russell
Mrs. Rudolph H. Schilling
Miss Marian Sinton
Mrs. Louis Sloss
Miss Ruth Turner

HONORARY MEMBERS
OF THE CORPORATION
Mrs. Andre de Limur
Mrs. Joseph C. Fennelly
Mrs. Herbert Fleishhacker
Mrs. Herman Phleger
Mrs. W. Stanley Whitaker

BOARD OF TRUSTEES
Mr. A. H. Brawner
Mr. John R. Cahill
Mr. Colbert Coldwell
Mr. Richard P. Cooley
Mr. James Crafts
Mr. James Flood
Mr. Peter Folger
Mr. B. R. Funsten
Mr. Peter Haas
Mr. Marco F. Hellman
M llington S. Henderson
Mr. Peter McBean
Mr. William H. Orrick, Jr.
Mr. Herman Phleger
Mr. Dean Witter

L. S. Kimbrough, M. D.
Project Officer
Continuing Education in Health Sciences
University of California Medical Center
San Francisco, California 94122

Dear Dr. Kimbrough:

In reply to your letter of February 7, 1969, I am pleased to submit the following answers to the questions you pose:

1. Level of practice in the community hospital - of good quality.

2. Weaknesses as far as practice is concerned - Group relationships are not too strong among the doctors. Failure to use latest automated techniques; failure to use ancillary health personnel; failure to keep abreast of current literature; failure to review critically cases under treatment in the hospital during the course of therapy.

3. Discuss in detail the strengths as far as practice is concerned - One-to-one relationship of physician to patient.

4. Areas of potential improvement - Continuous educational process is essential, not just one conference a year.

5. What could be done to improve the medical care in the hospital - clinically and administratively - Continuous review of cases under therapy in the hospital; continuous convenient lifelong education on a daily basis in the course of the doctor's work; weekly conferences; monthly review sessions.

6. State problem areas in the community itself - Lack of good group practice relationships, lack of ancillary help personnel ranging from residents to non-medical assistants.

7. Use of ancillary services - Latest techniques in automation and technology are not being currently practiced. Ancillary health personnel not extensively used.

8. What about referral service - A one-to-one basis occurs. Doctors refer cases only if they feel consultation is indicated.

3700 CALIFORNIA ST., SAN FRANCISCO, CALIFORNIA 94119 • 221-1200

9. Recommendations as to methods by which the Medical Center can best meet the educational needs of the physician and the community -

a. A continuous convenient form of lifelong education is essential. I think the best approach to this, personally, would be through weekly rotations of California Staff physicians conducting rounds in the Stockton hospitals. The present program provides some convenience, since the instructor goes to the home town. This permits the doctors to continue their work there, and not suffer economic loss during the educational process. However, conducting this only once or twice a year is inadequate to meet the needs of the community. It should be at least on a weekly basis.

Sincerely,

Victor

Victor Richards, M. D.
Chief of Surgery

VR:cef

Report of Dr. Morley Singer on visit to Scenic General Hospital
Physicians-In-Residence Program
January 7, 1969

I was scheduled to visit this hospital for 3 days, beginning January 7. I received notification of this in a letter dated October 21, 1968, from Dr. Farber. I did not receive any further communications from the Department of Continuing Education, but phone to check and confirm the dates a week prior to leaving and was instructed by Dr. Kimbrough that everything was set.

On arrival in Modesto, it quickly became apparent that Dr. Todd, the medical director at Scenic General was not expecting me. His secretary found some correspondence which seemd to indicate that he should have been expecting me. My visit had not been publicized in the community, nor the talk to the County Medical Society scheduled, and Dr. Todd explained it would be very difficulat to contact all the interested parties on short notice. We elected to stay for the one day, and lecture to the house staff, nursing staff and available local physicians, which made a group of about 20 people.

Because of the short stay, there was little opportunity to go into any depth in appraising the medical community. Some interesting information did come to light from conversation with a local physician and several house staff members.

All the hospitals (4 or 5) in the community, were in competition with each other, and each therefore had a small coronary care and/or intensive care unit. To maintain such a unit with a small number of beds is extremely inefficient and uneconomical. Each unit has difficulty keeping an adequate nursing staff, and raises salaries to attract nurses. Each unit must duplicate the expensive electronic and resuscitation equipment necessary.

It would significantly improve patient care, and decrease patient costs if one hospital in the community provided the service of coronary care/intensive care with a well-equipped, well-staffed unit, which would have a more stable patient census and nurse-patient ratio. This fragmentation of intensive care areas should be of great concern.

Dr. Todd indicates there had been some efforts to build a new wing and expand the Scenic General. As he stated their bed occupancy was around 70% and that most of the private physicians in the community favored the other hospitals, I cannot conceive for what purpose the new wing was intended. Dr. Todd did not offer to show me the physical facilities of the hospital so I cannot comment on them.

The general mood of the hospital seemed rather sluggish and the medical director not particularly enthusiastic. The visit was most unsatisfying.

5/29/68

Report on Physician-in-Residence Program at
St. Joseph's Hospital, Stockton
May 17-18, 1968
by Dr. Lloyd H. Smith, Jr.

CONFIDENTIAL

On Friday and Saturday, May 17 and 18, 1968, I served as a visiting Professor of a graduate course in Internal Medicine at St. Joseph's Hospital in Stockton. This was a very enjoyable experience for me, although a rather intensive commitment over that period of time. With the exception of the evening seminar, all of the teaching exercises were held at St. Joseph's Hospital in their excellent facilities there. On Friday, from 10:00 a.m. until 12:00 noon, with the exception of a ten minute intermission, we discussed problems relating to Gout and uric acid metabolism. The format used, seemed to me a very successful one. Specific problems and the diagnosis and management of patients were presented and the salient features of each patient were then discussed. Perhaps six or seven such patients came under discussion at this session. Following this I then gave a somewhat more formal lecture with slides on the general topic of Gout from the historical and scientific standpoints. This allowed me to set in proper perspective many of the more immediate practical problems of managment that had been introduced with the case history method. There were perhaps thirty physicians in attendance for part or all of this session. The questions were very good ones, particularly as they related to problems in being in clinical practice. In the luncheon period I spoke for perhaps one hour on the topic of "Current Concepts of Genetic Diseases". Attendance was quite good for this session, with perhaps forty or fifty physicians present. There seemed to be a considerable interest in this general area and questions were relative and often surprisingly sophisticated. This was the one session within the two days in which immediate practical implications were not emphasized and an attempt was made to give something of the background biological information to help the physicians understand how genetic diseases cause disability and what types of treatment can be used. After an intermission of only fifteen minutes, the afternoon session was devoted to the general topic of "Kaplar Kidney Stones". The same format was used which proved to be so successful in the morning session on Gout. A number of individual cases were presented together with x-rays and laboratory findings to illustrate specific problems in diagnosis and treatment. Once again, this was followed up by a general talk on the problems of Kidney Stones and the modern diagnostic and therapeutic approach to these problems. Another session lasted until about 4:30 p.m. in the afternoon. We met again at 7:00 p.m. for a banquet with the topic of the evening being that of "Continuing Education in the Community". This proved to be an extremely interesting meeting. I gave a short speech, but there was active participation from many of the physicians present. Even after the formal program was discontinued, a number of them remained around to talk further until almost 11:00 p.m. We agreed that the major impetus for Continuing Education must come within the community, perhaps built around a strong focus of the Community Hospital and its own teaching program. The University can be of direct and indirect assistance, but cannot assume final responsibility for this teaching program. Some of the problems in trying to attract the "Untouchables" into this kind of Continuing Education were discussed quite frankly.

On Saturday morning, I attended the regular Pathology session at 8:00 a.m. Two cases were presented as unknowns and we had a very good time discussing them, followed by the Pathological presentations. This session occurs there every Saturday morning but is usually poorly attended, now it seemed to me to be a natural focus around which to build an expansion of regular post-graduate training at St. Joseph's Hospital and for the Stockton area. Following this we had a session on "Systemic Manifestations of Malignancies". Once again this was predominately carried out by the case method type of presentation from patients actually seen in the Stockton community. They were able to come forward with a number of very interesting patients including Thymoma with a plastic enemia, lymphoma with a gammaglobula enemia, carsinoma with hypercalcimia, and carcinoma with consumptive coagulopathy. Once again after a short recess, I gave a CPC as an unknown which turned out to be an interesting patient with the rare disorder of pulmonary fibrosis complicating the sulthan treatment of Polycythemia Vera. The pathological discussion of this case was very sophisticated in that very careful studies had been carried out in the Pathology Department at St. Joseph's. This carried through until around 12:30 p.m.

All in all I believe that this was a most useful experience. The physicians seemed to be generally interested and most appreciative of the time given to this program. The Friday night session on Continuing Education is certain to have repercussions in the planning for Continuing Education in the Stockton area. They spoke of the possible reorganization of their committee under the local Medical Society to see that this took place. I was very pleased to note the interest expressed in the University of California program and that a number of physicians in Stockton make the long trip to San Francisco weekly to participate in our Clinical program here. I hope that this brief report will be sufficient, but if you would like to have additional information please let me know. As your records show, Charles Carmen was visiting Professor there on Thursday. I believe that his exposure was equally intense. Undoubtedly he will write to you independtly.

Report on PHYSICIANS-IN-RESIDENCE Program
Tulare General Hospital
May 20-22, 1968
Dr. Gennaro Tisi

CONFIDENTIAL

Dr. K: Dr. Tisi, you obviously had a very successful trip down there in Tulare. What would you say would be your overall observation of the level of practice?

Dr. T: The level of practice is that of a community hospital, staffed primarily by general practitioners. The general practitioners are close to 60 years of age and most of them have graduated prior to 1940, so they're practicing general medicine at a level which---let's say they need some help. Let's leave it at that.

Dr. K: Would you say that's their major weakness?

Dr. T: Which?

Dr. K: The fact that they are old and practicing antiquated medicine?

Dr. T: No, I don't think that they're practicing antiquated medicine. I think that because of the nature of when they got out of school, and because of the fact that they were just limited to a year's internship, they were not exposed to the extended type training that people are now. And since they were'nt up on the developments at the time they graduated, as the years have passed, it has become more and more difficult for them to keep up because, really, they don't know the vocabulary of any of the fields that have developed since 1940. And this includes almost every major field area of medicine, so that these poor individuals have been out in practice and they've been practicing at a time when medicine has been forging ahead, and for one reason or another, have not been able to keep up.

Dr. K: Well, that's an interesting observation of the weaknesses. Now, what about the strength down there---the brighter side? Did you see, in your visit, anything that you thought was up-to-date?

Dr. T: Yes, they have, obviously the members of the staff which, or who, have had more training and have been trained more recently, such as their medical director---they have been practicing excellent medicine I think. Their surgeon, Dr. Escobar, is well trained and practicing good medicine. And Dr. Wong, who was trained in Canada, is practicin excellent medicine. The medical director is doing what he should be doing---trying to help the five or six GPs on the staff in managing the problems other than the simple sore throats. So that's the brigh side. But I think, as in any area where you have a hospital which is primarily controlled by more elderly type physicians who have not had the advantage of more specialized training, they have deficiences. However, since the majority of the things they deal with are common problems, this deficiency isn't that great. The majority of medicine they see is common down to earth medicine. They see the Pneumonias, and Gall Bladders, and the Appendices and the Hernias, and to bring them up to date in these areas would not entail an extensive sort of approach. To attempt to bring a group like this up to date with respect to all the modern developments, would take honestly years, but this is not the kind of medicine they're seeing and not the kind of medicine they're expected to practice in their area.

Dr. K: What about the areas now of potential improvement? I think you've touched on this once before but . . .

I T: I think what they really need is somebody to come in from the outside, on a very practical level. They don't need someone to come in and tell them about the esoteric things in medicine---about the things that may happen in the future. They need someone to come in and tell them what is true now and what they can apply to their practice now, and what involves the majority of their patients, and these are the common diseases. They need to be told about the common forms of high blood pressure, not the exotic forms of high blood pressure. They need to be told about the common methods of treating infections, not the exotic methods of treating infections. This would be the simplest way of getting the caliber of medical training up.

I . K: What about the areas of potential improvement, administratively? Or, did you notice? You mentioned that the administrator . . .

Dr. T: I think that the administrator is doing an excellent job, because he's trying to get the men to get current---to read the journals, to report on their grand rounds. He's trying to organize some sort of teaching program among themselves. If nobody comes in from the outside, they have no alternative but to organize from within. And they're making this attempt. They have one man talk on one subject, and then the next week somebody will talk on something else. They have a library which gets all the current journals, the common journals and the exotic journals. They have good ancillary facilities. The radiologist that comes in from the outside is good. The lab is generally excellent with the exception of the department. Very primitive. But the Cardiography is good. So the ancillary thing is good. I didn't have much chance to observe anything about the nurses or level of nursing care or the level of nursing training. None of the nurses attended any of the sessions.

Dr. K: What about your estimation of the major problems in that community?

Dr. T: The major problems are the type of people that are being treated. Their attitude toward medicine in general, the facility in which they are being treated, and of course by whom they're being treated. In other words, the patient population is very indigent, very mobile, very---lets call them just medically untrained. They don't come in for care when they first get sick, they wait five years, ten years, and when they come they have the more advanced types of diseases. They have no appreciation of clinic medicine, I mean the patients. They expect to go to the doctor and give him a symptom, get a magic pill and go home and take it for 2-3 days, and be cured. They have no concept that they take the Insulin for the rest of their lives. Or take the high blood pressure medicine for the rest of thei lives. So this is the problem with the patients. They need to be educated. To seek medical care when you first get sick. The second thing, the hospital was built in 1926, and even though it has made attempts to keep up, there are obviously all the organizational problems that go with the building that's approximately 50 some odd years old, and the third problem obviously is the general level of awareness of the physicians treating the patients.

Dr. K: What is the predominant cause, of morbidity in the area?

Dr. T: Alcoholism. Well, anything that goes with alcoholism. Anything short of Cirrhosis, the family breakdown and the problems that go with it; the economic problems that go with it--they are all there. And any medical problem that the patient has to be treated in this life, like TB. You know that the patient, once he's released, more than not when he gets drunk, he's going to stop taking his medication. And this is why they wind up with TB---they're resistant to the different forms of medication. It's like treating any other population that doesn't attend to the thing they are told. If they take one form of medication for three months and then come back, they still have the TB, they need prolonged treatment. I think this is one of the biggest problems up there, to convince people that they need to be treated for long periods of time, and with the alcoholic population, I don't know what the solution is there, but they need treatment, but their alcoholism really prevents them from getting it.

Dr. K: Now, this is a big question---what suggestions do you have for improving the overall care in the hospital?

Dr. T: I think the biggest thing that can be done---I think the men who are there are very interested. They want to become current. They want to learn the things that are helpful to their patients. They all took notes. They took avid notes. They passed questions. They came to eight different sessions that we had, so they were interested. I think what they need is a way to bring the hospital up, to have people talk to them in various sub-specialties on a very practical level. Considering first, when they got out of school, which means they got out of school, most of them, before 1940

Secondly, their age, and third the fact that they are not familiar with the vocabulary in any of the sub-specialties so if they have somebody go and talk to them and he starts out using terminology that they are not aware of, he will lose them and they will get no benefit from it. So, if anybody does go down, they have to start from scratch and saying right now---he knows what advances have been made since 1940, and he should assume that everything he tells them, he should start from 1940 and work up. Giving them a basic terminology in his sub-specialty can take in a matter of a day or so, and then give practical applications over the next day and a half and if this is done on a practical level in each sub-specialty, it has to be really chronical. It's got to be done at least one visit a month, I would imagine, to get any sort of benefit out of a program like this.

Dr. K: At one time the question came up---should we bring a group of doctors from the community to the University Medical Center for a period of ten days, and this was abandoned because they didn't have anyone who could replace them in the community. Do you think this idea would work?

Dr. T: I think the best place to approach them is where they are, because every hospital . . .

Dr. K: . . . In other words, approach it like the poverty program?

Dr. T: No, I think every hospital you visit is going to be different and they have different deficiences, and when he gets there it'll take him a matter of a half a day, but he'll feel out where the problems are and if they come to him, why he has no concept of what kind of physical structure they're working in or what kind of . . . if he just walks through the lab and sees what kind of machines are turned on, sees which machines are clean, asks a few questions of the technicians, he can very rapidly judge what the level of sophistication is that they have. If you bring the physician here, he doesn't have that ability.

Dr. K: What about the potential for referral for these patients? Do you think these patients are kept and treated there when they have a problem that should be treated elsewhere?

Dr. T: I don't think so, I think the medical director is on top of those people who can be really treated best elsewhere, and makes these people get them out. If they have common problems, they'll treat them there. If they're beyond their scope, they'll transfer them. But the basic problem is, like everywhere else, there can be only one center that can afford all the isotope machinery and everything else and all this expensive gear. It will never filter down to the community hospital, because in one area there are four or five community hospitals, and you can't spend a half a million dollars to put all this machinery in every hospital. And even after you put all the machinery in the hospital, you don't have the people to run the machines.

Dr. K: Do you think it might be possible to establish, as they're doing in some of the hospitals we're visiting, a sort of a screening device whereby patients who should be referred to a major medical center . . now, do you think that such a program could be beneficial to this hospital?

D.. T: I don't think you can ever take the patient away from his doctor. I mean you have the big problem in the area that the people are indigent. They have difficulty in forming doctor/patient relationships to start with. The people go to the clinic---that's the first successful step. As soon as they get to the clinic, if you wrench the patient out of there and send them to someplace else, that first doctor with whom that patient has formed a relationship, he's lost. Not only is he lost, but now the patient is lost. He's being shuffled around. I think you have to attempt to let them treat whatever they can, in justice, treat in their hospital. When they have their head below water, then transfer that particular patient out. But the majority of people can be treated there. I think most of the people have to be approached with simple histories and simple physical examinations. Ninety per cent of the diseases they have, they can be diagnosed and adequately diagnosed, just on the basis of the history and physical. If they add a simple chest X-Ray and a Cardiogram and a CBC, the majority of what they're seeing, they're seeing the common medicine, they're not seeing the exotic things that you see at UC, and to attempt to just wrench people out of there, I don't think that's a good approach.

Dr. K: What about in cases of surgery where cases of shock, and so on, do you see much of that being done?

Dr. T: I can't make judgments on that, because I didnt see. They have a thorasic surgeon who's supposedly well trained in thorasic surgery. And I would expect that he would do good thorasic surgery. Now, I won't make a judgment on what they're doing surgically, because I didn't see their surgical schedule.

Dr. K: So I gather that, from your conversation, that this trip was not in vain, that you . . .

Dr. T: Well no, I think it was one of the most . . . well, of course, I learned a tremendous amount about different levels of training, and different levels of medical practice. Second, these people are like sponges. They want to learn, they want to become current, and they really are just . . . they're dry, and they'll sop it up. If you talk to them and talk to them at a reasonable level, you can carry them right along to a respectable level of sophistication in a couple of three days. In any sub-specialty---and I think that this is what they need. They need somebody to come down and stress the common things, that you examine the chest in this fashion, you percuss it and so on and so forth. They have to be exposed to the common things. They can't be told about the isotope scanners and the sophisticated computers and all this because when it gets down to the end of the story, they have their hands, their eyes, and their ears, and they can do most of what they can with those. And those are the first capabilities that have to be restored, not bringing them up here and have some out-in-the-clouds physiologist talk to them about   and things like that.

Dr. K: What do you think their next program should be in your . . .

Dr. T: I think that would be up to the medical director. He knows what areas they're most deficient in.

Dr. K: From your observation, what would you . . .

Dr. T: I'd send somebody in infectious disease.

Dr. K: In infectious diseases.

Dr. T: They need somebody who'll go down there in infectious disease. Not only to tell them about the clinical problems, but to acquaint them with the simple bacteriology, and his responsibility when he goes there should also be to check out the technician in that area, and if the technician is a problem, to try to either correct the problem or eliminate the technician, one or the other.

Dr. K: Do you think that three days is too long?

Dr. T: No, I think that three days is just about right. They reach a point of saturation.

Dr. K: And how often should we have these sessions?

Dr. T: I would say once a month . . .

Dr. K: We get them for every four months.

Dr. T: That's much too far apart. You get them enthused, you get them interested, and if you make it every four months, I think their interest and enthusiasm will abate. If you hit them on a regular basis, I'd rather take one hospital and send twelve doctors to that one hospital, than send four doctors to three different hospitals over a period of a year. I think if you're going to concentrate to elevate the level of medical care, if you do it in a sporadic fashion, you're going to wind up with four inefficient places. This place administers to 170,000 people. They see 60 people in the OP Department a day. They have 100 people in the hospital at all times, and that's alot of people for this group of doctors. I'd concentrate on that one place on a real regular basis.

Dr. K: I wonder if we can ask you to go back in one year from the date that you went down, and then again we'd like to talk with you.

Dr. T: I'd love to go down, however I'm heading down to the University of San Diego in La Jolla, and it entirely depends upon what I'm doing at that time in La Jolla. I'd be delighted to go back. I really got a huge kick out of being there. I think really that this is the whole problem in medicine. In San Francisco, New York City and Chicago, people can eventually get to any kind of medical care because it's in the city, but when you leave the big city---this is the problem everywhere. It's not only down in southern California.

Dr. K: Yes, but there is another thing---in my five years here in Continuing Education I've observed this constantly. There are a hundred and some odd courses we put on here, our TV programs, and our radio program, medical network throughout. We get very few doctors attending these conferences from the major cities like Sacramento or even San Francisco---and they're getting theirs by some sort of osmosis.

Dr. T: I don't think that's true. I think in Sacramento and big cities, you attract the more recently trained individuals, and there's a free interchange between the younger individuals. In other words, if everybody between the ages of 35 and 45---and you have with a group of ten doctors, or ten associates---somebody's a Hemotologist, somebody's a Cardiologist---they can train each other.

Dr. K: Even the mere fact of visiting your patient in the hospital, you have a chance to correspond or contact your colleagues in there, and this in itself is a form on continuing education.

D. T: This is the best form of education as far as any major community is concerned, is how medicine is advanced and kept current in most communities. In the communities that are around the university centers it becomes easier because the university trains the doctors, alot of the doctors stay in the area, go to these ancillary or outlying units and bring into that hospital what's currently known. And two or three years later somebody else comes from that university into that area and brings up what's happening in that two or three years. And this is why the bigger cities don't have this problem, because they attract the people with more sub-specialty training. They attract the people who are more recently trained. And these people more or less have their own intrinsic stimulation from their own groups, even if they're not in a group. By their consultation back and forth, they'll elevate their level of knowledge.

Dr. K: It is often said that when one graduates from a medical school, that the moment that he walks across the stage and gets his diploma, that everything that he's learned up to this point is outdated. Would you say that this is a true statement as far as the physicians in the outlying area are concerned today or would this be true of the city physician?

Dr. T: I don't think it's true at all. There are people in the medical school now and it's certainly becoming more true now that it was ten years ago or twenty years ago---he's learning the basic machinery he needs to keep up with whatever change that occurs. He's learning a sound physiology, biochemistry and what he needs to appreciate any change that occurs. And this is how medicine is different now from what it was thirty years ago. More basic science appreciated, more basic sciences transferred to people, and they're given the basic equipment they need to keep up with any development. I don't think the training is outdated at all. I think it's the physiology---it doesn't change, and if the principles are sound they can be extended but the sound principle is still there. And I think that this is what most people come out of medical school with now. The common diseases remain common diseases, and the treatments for them remain common. The exotic diseases, since they are exotic and not understood---the approaches towards these change at times, but if one understands the proper physiology of the disease, this never changes in essence.

Dr. K: Well, Dr. Tisi, I want to thank you very much for being our . . .

Dr. T: Being a panel discussion? . . .

Dr. K: . . . on this, we went into this somewhat blind. We didn't know what . . .

Dr. T: I think it's a very beneficial thing but I think it's a crucial thing to make sure that the individuals who are sent are clinical people. The last thing they need is somebody to go down there and talk to them about . . .

Dr. K: . . . about theory.

Dr. T: Well, theory is great, and if you give them the theory first and then have them apply the theory to your sub-specialty, that's what they need. They need somebody to come in and say "Alright now, we're going to approach this at a basic level, we'll talk for a day on the basic things, then we'll see how these things apply to the common diseases in this sub-specialty." But, if you send down somebody who is just a physiologist, who doesn't see patients, he's accomplishing nothing. He's going to lose his audience, they're going to become more frightened, and they're going to become more insecure, and I think there would be more lost than gained by that kind of effort. I think when you send somebody you should speak to the chairman of whatever department and tell him the nature of the problem, that "I need somebody to talk to GPs out a number of years and I would like you to suggest somebody who can approach these men on a clinical level with some physiology," and then I'd leave it up to him to pick somebody.

Miss F: Did any of the other doctors from outlying areas come in?

Dr. T: Oh yes, two. I think that if more had known, they would have come.

Dr. K: . . . tried to give some advertising over medical network . . .

Dr. T: I think that it may have medical meetings and an announcement at a medical meeting the month before, and then a circular by the medical director of the hospital to all the doctors in the community. Just send them out a notice that "between this day and this day we will have a visitor and he will give lectures at these times, and some of the general things which are to be discussed are . . ." The other thing which might be helpful is if when the medical director of any community hospital says that "we'd like to hear about these five areas," if the doctor who is going to go down could send, in advance, a general article on each one of the five things. Now, it would have to be exceedingly general. It cannot be specific at all. Just to get them to read. Even if it's just a historical article, that this disease develops historically in this fashion, so you get them used to hearing the words that you'll be using when you get there. If he could send a bibliography of that type, not a sophisticated bibliography---far from it---a very basic simple approach and a very general article in each of the areas that he intends to talk about. If he does this a month in advance, and the gentlemen could read these five articles, let's say, and they could at least come to the talks having heard . . .

Dr. K: . . . with the vocabulary . . .

Dr. T: The big thing is the vocabulary. Once you have the vocabulary, it's simple. Always it's simple. And you spend half your life learning the vocabulary and once you have it everything flows sort of very simply. And I think that's their big problem, that everybody around them is using words which they take for granted, which are simple words, simple definitions, but unfortunately these things were defined after they got out.

Dr. K: Well, again, thank you . . . you've given us some valuable information. Use this to improve for the others, as a matter of fact we should have this especially in these areas. I don't think we need it for Stockton, because they have about 60% specialists, but I certainly think that some of the other areas that we should let the people who are going out read this.

Dr. T: I asked if I was going to be asked to write a letter. I said no. I should have said I don't know about a tape recorder!!!

PHYSICIANS-IN-RESIDENCE PROGRAM

YUBA CITY-MARYSVILLE COMMUNITY HOSPITAL

Hibbard E. Williams, M.D.

The level of practice is generally of fairly high quality. There seems to be two levels. There is a group of fairly young men in the community, many of whom are specialists recently and mostly trained in California, who are quite sharp. They're right on top of current medical problems, current medical literature; and do, I think, probably a superb job. There is a different level which is hard to criticize. It's a group of older physicians, mostly general practitioners, who have been in the community for many, many years and have large practices. I think the level of care here is probably somewhat less or a lower level than that of the younger people who are specialists.

The County hospital is very poor. It's a run down, dilapidated structure. The temporary building was built originally during World War II, and then kept as a County hospital after that. As a physical plant it's just horrible. I asked the new director, who had been there only about a week when I got there, about its occupancy. He said approximately 50% occupancy. I think there were approximately 60 or 70 beds in the hospital and their average patient population was about 30 to 35 patients, something in that neighborhood. It's run primarily by this director and two other people who I think are also on the part-time staff. I went around and made rounds with the director one day, and I think he's new and is full of some new ideas. What's been done there in the part has been pretty weak. Apparently from what they told me in that county hospital, they've had difficulty keeping a director for any length of time as it is. I gather that the nursing staff does a fair amount of the medical care, because for long periods of time there wouldn't be a director in residence, and somebody would have to do it. The nurses would take on the role. That county hospital was a big shock to me. In marked contract, is the Rideout and the Fremont Hospital, both of which are either new buildings or newly remodeled buildings and where most of the general practitioners and people in the community practice. The level of care there seems to be quite good. There's a new County hospital in the adjacent county, newly built, Hilberton funds. A very nice building, well set up, well planned for the care of the needs of the community, with a new staff. The director had some special training in community medicine, he's not a board certified specialist in any area. He's had some special training in community medicine in California. He has two people working with him, who he had come into the area in the last two years to work on the full-time staff of that county hospital. These are two young fellows; one with two years of pediatric house staff training, and another fellow who is nearly qualified. I think he's had two years of residency in medicine and perhaps two years in the service, at which time he did mostly internal medicine. None of them are board certified but I think at least one of them is board qualified. These fellows are young and interested in improving the care in that hospital. They are doing, I think, a good job. They have a very effective emergency room running, they run a night time clinic for the migrant workers and they see huge numbers of patients on an out-patient basis. It's really through their own motivation that they keep this clinic running. The three of them together make rounds in the hospital and from what I could tell, had real interest in improving patient care and were doing a pretty good job.

I think that in that particular County hospital is much more interested in having people come and discuss problems in medicine with them, than is the other county hospital. The population in that County hospital is also low. I think it's very obvious what they should do. They should combine the two. Apparently there's some discussion of this in the Board of Supervisors of the two counties. There are some petty differences, which are going to be hard to settle. I would look into that. I'm sorry I can't remember that director's name. He's been there for about a year, and his first name is Thomas. There are two people with him, Kellermeyer and Pflueger. I spent a couple of sessions over there.

318

They were very anxious to have me come, and to come back again. We had some good discussions. It's hard for me to criticize specific weaknesses. That community has the Marysville Clinic in it, which is a pretty high class, well run, busy, private clinic. Every sub-specialty covered, excellent things, such as an excellent physical medicine department. Surgical sub-specialities such as urology, orthopedics; two or three men in each sub-speciality. A good department of internal medicine. One or two bright people in pediatrics. That, I think, is a fairly strong area within that community. I would find very little to speak of in the way of weaknesses there. I think one of the overall weaknesses is the tendency for the medical community to be somewhat in-grown and conservative in their thoughts. I have a feeling they're quite happy with the way things are going, and don't rock the boat at all. Why change. On the other hand, I would say each of the sessions I was at, was very well received. In each case,had some interesting questions asked, which implied that the people there were interested in new thoughts about these things I was talking about. I'm sure like many communities, which tend to be isolated in a geographic sense, the medical care tends to remain static very often. There's not the interest and enthusiasm to change it or upgrade it. I don't mean to imply there's a serious weakness, because there were several men there who obviously seemed very interested in doing it. Overall I would say it was fairly reasonable.

One of the strengths, I would say, is the Marysville Clinic. They have a lot of specialty people there, that supply a fairly small area or patient population. This means that they can do much of their surgical sub-specialty work right there in town, do not require the people to be sent to San Francisco. They do referrals, and each of the people I spoke with there has had a very good experience with UC. They found UC helpful in taking their patient referrals. Dr.Salopek specifically, has a fair amount of contact with Dr. Forsham, Dr.Grimes and several of the other people I spoke with had had similar circumstances with patient referrals which they thought were handled very nicely. I asked them what the biggest problem was in referring a patient to UC, and they said the delay in getting the summary back, but that's fairly standard.

I think the County hospital is a definite area that needs to be changed. The migrant worker problem is probably a fairly sizable one in that area. I don't know enough about the agricultural community there. It's obvious the care of the reasonably affluent individual is reasonably good. That county hospital where I spent so much time, is very active in caring for migrant workers, there's probably a greater need than that one particular county can handle. Here is a public health area, that ought to be looked into with some seriousness.

It's generally unpleasant surroundings, and a poorly equipped physical plant to work in. The community has not supported that County hospital. Most of them don't want anything to do with it. Most of the physicians want hands-off. The medical community has not soundly, firmly supported that County hospital. That director has been sort of a lone wolf, trying to manage as best he could without much stimulation or support. He had very little intellectual stimulation, he was pretty much all alone. Little support from the community either emotional or financial. I doubt if his pay is very good, but I don't know what it is. It's mainly the lack of support in the community, particularly the medical community. In terms of other potential improvement, I think programs like I conducted there, are probably good, and they are probably needed regularly. There was a hiatus because of some administrative problem. If you can do this on a regular basis, that's probably an area that will be well received by most of the people there.

I talked for a long time with Dr.Salopek about the problems of the program format. Three days may be a little long. In a small community like that, some of the people get a little bit sick of you. The general practitioners just don't have time to take off from their practice. They can't just give up three days usually. I found a very interesting problem that I ran into. Dr. Salopek had advertised my talks, my official lectures in the newspaper and said they were open. On the first I talked about Rheumatoid Arthritis, and I had every little old lady in town with crippled arthritis coming in. Literally, probably 75% of the audience were laymen and the other 25% physicians. Because of the overwhelming weight of laymen in the audience I had to direct my remarks more toward them than to the physicians and this didn't go over well with the physicians. It might be wise idea to set aside some specific time for talks with laymen groups or with nursing groups, rather than physicians, and set up a more formal program of night lectures so perhaps the doctors can get there, rather than interrupt them during their practice, or luncheon meetings. Having rounds one afternoon or morning at each of several hospitals in the community. . .in this case, Dr. Salopek could have set it up differently. When I got there he was a little confused as to what I was really supposed to do, and I didn't really know, so we played it by ear. It's obvious that you can't expect busy physicians in a community to take three days off and listen to you talk that whole three days. You've got to plan it at different times to different groups of people. Evening lectures and luncheon meetings are good for the physicians and maybe one afternoon or morning on making official actual walking rounds. Sometime specifically set aside for the layman of the community. If we get mixed laymen and physicians then it's very difficult. I found myself in a fix trying to talk to both groups.

Mention this to the doctors setting this up, that if they're going to advertise, specify certain ones for laymen and not for the others. The first day was mostly laymen, probably 12 physicians. The second day there was an evening meeting. That was a smaller group; I had some laymen and maybe 12 or 15 doctors. The third day was a much larger group of physicians. The final day was a luncheon meeting in Fremont Hospital, and that may have been the monthly meeting of the County Medical Society. That was well attended. I had lots of physicians there I had a more enjoyable discussionon that day. Some of the people there are extremely bright. Right on top of things. They were asking questions. One fellow, a , up there knew all the current things. I couldn't tell him anything. He was asking me questions which we had a lot of fun with. He was right at my level. Perhaps some of the physicians up there are much lower down on the intellectual scale, but it was not terribly noticeable.

Clinically, they're excellent in Fremont and Rideout. They've got excellent nursing care, as far as I can see, and their clinical care was very good. The migrant worker is the major problem area, giving them adequate medical care. There were some ancillary services associated with the Marysville clinic. Like physical medicine, an optometry set-up there for getting glasses and a dental unit as well. I didn't come across any of the other ancillary community services. I gathered they used pretty much all UC for their referral. What they couldn't do there, they felt they ought to send to San Francisco. Some of the doctors use other hospitals in town here. They're many who prefer Presbyterian because of their previous experience with it when Stanford was here. I'd say the majority come here. I specifically, at the request of our chief resident in medicine, took the good word to them there. We've had a couple of referrals since I've been back.

I think this program is basically a good one. I think it has to be done on a very regular basis. Perhaps for shorter periods of time, maybe two every two months, or one day every month or, one day every two months. But some recurrent area of discussion such that over a period of a year or two years, every subspecialty will be covered. That's hard to do because it's hard to get internists to come hear an orthopedic surgeon, and it's hard to get surgeons to come and hear somebody . But I think the community is sufficiently interested in this to take some time out. Again I would have to emphasize the fact that three days is a little hard, to hit the same group over and over again. If I had the time, I would be willing to go back again. Overall, I would say I enjoyed it. I was very well treated. Dr. Salopek really socially took me under his wing, and it was a very pleasant experience.

323

SPECIAL REPORT--

Memorial Hospital at Exeter
September 16-18, 1968
Dr. Roger H.L. Wilson

The cooperative pathologic services developed during and as a result of the physicians-in-residence session. The chief pathologist, Dr. James Sargent, has been there for six years. A highly trained individual from Cedars of Lebanon Hospital in Los Angeles, he inherited a situation where the pathologic services in the area were more or less restricted to coroner's autopsy cases, some tissue work and practically no chemical or bacteriologic investigation. During the six years he has been there, the situation has become vastly transformed largely because of his great interest in clinical medicine and problems where the pathologist may contribute to therapy. I have seldom seen a pathologist with closer rapport with his referring physicians, particularly in clinical and therapeutic matters, where his advise was constantly sought throughout the three days that I was there. For the last year he has been joined by Dr. Jude Hayes an equally accomplished and exceedingly clinically oriented pathologist who trained with Dr. Beldon Scribner in Washington. Their status in the medical community has essentially become that of accepted innovators and developers for improving the standard of investigation and care of patients. As well, although there is only a limited number of specialists in the area, it is sufficient that exceedingly complicated work is normally done in these hospitals, but most particularly at Exeter. For example, during my stay transthoracic repair of a hiatus hernia was performed at Porterville and a total colectomy with abdomino-perineal resection at Exeter by one of the local board certified surgeons. The great majority of physicians in the area are general practitioners falling into the older age group. The relationship, however, between the specialists, who tend to be younger and the rather older general practitioners is quite excellent and their assistance and consultation appears to be continually sought.

The hospital is a one-story unit with an excellent extended care wing. The general structure is a U-shaped corridor with central nursing stations. The laboratory is capable of doing most of the standard investigations including isoenzymes and electrolytes, etc. There is a shuttle service to Visalia for more complicated procedures. The x-ray department is particularly well developed with three diagnostic machines, one of which is equipped with television, another with an image amplifier, and a third adapted for tomography, etc. Such procedures as angiography are commonplace. There are as well two therapeutic machines, one of which is a cobalt unit. I somewhat question the need for this although I am told that this is being used for the whole area. The physical therapy department is particularly well-equipped and large by any standard. This was developed during the days of poliomyelitis when Exeter was the local center for treatment. In contrast, there are serious problems such as (1) no pharmacy, (2) limited blood banking facilities, (3) no development toward even partial intensive care, and of particular relevance to this visit, (4) no facilities whatsoever for pulmonary function evaluation.

It was in this context that this reporter was selected as a physician-in-residence and for the six-weeks prior to my visit, a considerable correspondence and telephonic discussion was held with both the chief of staff and the chief pathologist. I might mention at this point that my time was fully occupied from seven o'clock Sunday evening to three o'clock Wednesday afternoon. For purposes of record, Sunday evening was spent in conferences with the chief surgeon and pathologist; Monday morning in consulation with Doctor Hayes, the second pathologist, who had arranged to attend the pulmonary function course presented at the San Francisco General Hospital later in the same week. A twelve o'clock noon meeting was spent in discussion with three of the general practitioners who are involved in pulmonary dysfunction problems in particular. The afternoon was spent in further discussions with Dr. Hayes joined by Dr. Sargent, with Dr. Ward Evans, the most prominent surgeon, and a visit to Lindsay and Porterville Hospitals; and the evening in individual discussion with about thirty of the practitioners in the area as well as the hospital trustees concerning the kind of meaningful program that might be inaugurated. Tuesday morning was spent with Dr. Sargent in the development of an actual protocol for pulmonary evaluation in the following circumstances:

1. The patient with pulmonary difficulties at an outpatient level;
2. the patient with pulmonary dysfunction either consequent to surgery or with prior difficulties and risk of complications;
3. the hospitalized patient with pulmonary dysfunction as with a severe infection but not requiring emergency major measures; and
4. the patient with severe respiratory acidosis and cor pulmonale.

The lunch time meeting was rather better attended (8) and was devoted to problems of screening in the doctors office. Follwing the luncheon meeting, a one hour session with more than twenty nurses (RN only) was devoted to three major areas where the nurse essentially must take over many of a physician's functions. These were (1) management of tracheostomy, (2) positive pressure breathing therapy, and (3) avoidance of postoperative pulmonary complications. Parenthetically, I might remark that even in a university medical center with full time inhalation therapists, instructions are generally so vague in these matters that constant dilemmas are experienced by nurses, and best therapy and prevention of complications is frequently not achieved. These problems are far more serious in such a hospital as Exeter, where avoidable respiratory problems constitute an important cause of death or prolonged hospitalization. The rest of the afternoon again was spent with the pathologists working on these protocols together with a second protocol to be distributed to all physicians in the county concerning the management and follow-up of patients with chronic respiratory disorders. The evening was devoted to an overflow meeting concerning the nature of pulmonary emphysema, problems in the clinical management, and the whole question of screening, evaluating and continuous follow-up. Wednesday morning was devoted to the development of some of the changes in therapy practiced in the community which appeared to be of particular importance in improving physician service as well as the final review of the evaluating process, development of a report type sheet and special sheets that physicians would use to maintain a clear picture of how their patients were doing as they follow them along. The lunch time meeting was well attended by twelve physicians and the discussion was devoted entirely to the problems of the surgical patient, his anesthesia, and the management of pulmonary problems consequent to this. This was followed by a long consultation with the new anesthesiologist who had just arrived in the area, concerning the kind of approaches that he could profitably introduce at Exeter Hospital where he is full-time.

As a result of these meetings, a definite timed plan of development has been adopted which will be under Dr. Sargent's immediate direction with a consultative group of the hospital staff headed by the chief of staff. Arrangements have been made for Dr. Sargent to visit my laboratory at the San Francisco General Hospital, and the equipment necessary for this simple type of evaluation has been put on order. Portocols have been prepared for distribution to all physicians in the county concerning the type of evaluation which should be done and how it will be achieved, together with the recommended procedures in following these patients in physicians own offices. As well, copies of written instructions to patients to assist them in developing their own ability to help themselves have been prepared for distribution. These are filed as appendices together with examples of the type of form used in my laboratory (to be adapted) and the type of physician reporting form which we use.

Achievements

In the area of chronic pulmonary disease, it seems clear that a positive program with the beginning of evaluation and potentials of management for these patients has been initiated. The target date for start of the actual program is November 1, 1968. A major change has been developed in the handling of patients who either are presently with pulmonary problems or develop them in relation to surgery. Complicated in-patient respiratory problems will now receive attention in their evaluation which did not previously exist. The procedures will be learned and developed by members of the staff of the hospital who will come to study in my laboratory at the San Francisco General Hospital during the month of October. It is proposed that Stage II will depend upon this reporter's December visit as physician-in-residence at Tulare where facilities for intensive care are being developed for seriously ill patients in this area and for a satellite in Visalia where such investigation as blood gases will be started tentatively in January or February, 1969.

Despite the concentration on pulmonary problems, other matters were also opened for discussion which will affect the physician-in-residence program at Exeter. This area has one of the highest automobile accident rates in the country partly as a result of the partial freeway nature of U.S. 99 and partly because of the kind of roads that exist east of the freeway which are long and straight with blind entrances and exits. There is a high incidence rate involving migrant farm workers commonly not possessing drivers' licenses and as well, a marked association of drunkenness. It is anticipated that the accident rate will increase vastly within the next two years since a new resort development east of Exeter is actually being built. This will include a very large ski complex as well as a Disneyland type of operation, and a group of resorts for hiking, horseback riding, etc. This is a huge project opening a major "Vacationland" on the west slopes of the Sierras and will not only increase traffic, but in itself will be a source of further accidents. There is already a young orthopedic surgeon who came to the area in view of this, and the question has now come up of the development of an accident unit either within the existing hospital or as an addition to it in order to cope with not only the present situation but the far more acute situation which is envisaged.

Lastly, in this context, Dr. Sargent and his colleagues' attitude was that this required the study of other models, and we are discussing with him the question of sending for the third visit, Dr. George Torassa, from Mary's Help in San Francisco, who has developed a unique unit for these kinds of accidents. (Note: Dr. William Murray's residence in Reno for similar reasons).

Another facet which is to be presented to the board of trustees is the development of a partial intensive care unit with the necessary architectural changes, knocking a hole through from the main acute nursing station into the adjacent right hand room which contains four beds, permitting a far closer observation of the patient. It was my personal feeling that acutely ill patients were too dependent upon their own cooperation in getting help, and it was the concensus of those physicians whom I met that this was indeed true. Since this will require architectural change, together with some improvement of equipment, this is to be presented to the board of trustees, several members of whom I discussed this with as a needed development. I have every reason to believe that positive action will be taken.

In General Summary

I would comment on the extremely friendly approach which I found in this situation. I found a real demand for the development of services possible within the institution and in relation to other institutions. I found an attitude of wishing to implement suggestions and desire for continued cooperation in relation to an actual planned project. I found a leadership group acceptable to the medical community, capable in the past of producing extraordinary innovation in what was a very backward area, who are dedicated to further implementation toward higher standards of medical care.

On the negative side, I found a certain diffidence among the older practitioners with a reluctance to present actual cases where cirticism might be thought to be made of their management of problems. While consultation with local specialists was common, there seemed to be little consultation between general practitioners themselves and a certain independence of practice with lack of mutual discussion, which is frankly an undesirable situation in any community. I also noted that those attending postgraduate courses of one kind or another, almost exclusively fell into the specialist group. This perhaps is a positive factor in a way, since I was assured by every physician I met that this question of bringing physicians into the community was really the solution that they needed toward elevating standards of medical care. I am told by my predecessor, as well as by the physicians I met, that this kind of program will become increasingly acceptable as the diffidence caused by a new relationship wears off. I believe this to be true since the difference between the first and last day of this brief visit was quite obvious to me.

SUGGESTED PROTOCOL FOR EVALUATION AND MANAGEMENT OF PATIENTS WITH CHRONIC OBSTRUCTIVE LUNG DISEASE

A. INITIAL EVALUATION OF THE PATIENT

Since this phase is what we might call a minimal adequate investigation of most patients the whole procedure is necessary to give a reasonable therapeutic goal for the physician. Except in the case of sputum analysis in the patient with no sputum all procedures should be followed and preferably a form prepared which we will provide Dr. Sargent on which all results will be put in one place rather than scattered through the physician's ordinary chart.

Spirograms

Spirograms done in a hospital should be done with an instrument capable of recording a tidal volume. The patient should come in and be rested for a period of at least 20 minutes before any procedure is done. The patient should not be smoking. At this time any notes on medication, particularly with reference to any medication that morning should be obtained. These should be typed in on the form. After 20 minutes a Spirogram should be performed. The patient should breathe quietly into the machine and on instruction take a full deep breath and then express it as hard and fast as he can until it is all out. He should return to quiet breathing for 2 or 3 breaths and repeat this process twice. The value to be measured is the highest value. The total vital capacity, its partitions and the 1 and 3 second forced expiratory volume (FEV_1 and FEV_3) should be obtained. The patient should be detached from the machine to do a peak expiratory velocity (PEV should be done also 3 times asking the patient to take a deep breath and get the air out just as fast as he can to make the pointer rise as high as possible.) The highest value is the value used. The patient should then be given 3 squirts with a medihaleriso nebulizer and rested for 15 minutes. Spirography should then be repeated with PEV values. Then, an intermittent positive pressure device (either Bennett or Bird apparatus) should be given for a period of 10 minutes. The type of equipment should include a "hot pot" and no medication other than water supplied. A Spirogram, etc. is then repeated for the 3rd time. These will be calculated depending upon the type of machine used.

SUGGESTED PROTOCOL FOR EVALUATION AND MANAGEMENT OF PATIENTS WITH CHRONIC OBSTRUCTIVE LUNG DISEASE

B. THE PATIENT WHO REQUIRES HOSPITALIZATION WHO DOES NOT APPEAR TO BE CRITICALLY ILL BUT IS CONSIDERABLY WORSE AND UNABLE TO GET AROUND

Same routine of spirograms and $PACO_2$, cardiogram, sputum examination, CBC with hematocrit should be followed but inspiration, expiration films are usually not particularly informative unless the patient is known to have a cystic process so that simple radiography is enough. If the $PACO_2$ is not elevated the patient will usually respond to bronchial toilet, bronchodilators and, in some cases, steroids. Intermittent positive pressure breathing (IPPB) would be used purely as a method of encouraging sputum evacuation from the chest. The physical therapist should see the patient concerning bronchial drainage. In the average patient, daily spirograms are in order because it is here that one can see either a success or a slow diminution despite therapy which should put one on guard. Naturally peak expiratory velocity (PEV) should be done with every spirogram since it is part of the spirographic examination. If, at the end of two days, little progress seems to be made then the sputum examination may be the clue and a change in antimicrobial therapy indicated. Any rise of $PACO_2$ at this time should be regarded as an ominous matter and more intensive IPPB up to 15 minutes in the hour while awake may be required. The other questions of hydration and so forth are beyond the scope of this protocol.

Patients admitted with an elevated $PACO_2$ who are still cooperative and whose levels are not above 65.

These patients require ventilation. We have found in general that a cooperative patient will in fact treat himself at least 15 minutes in the hour while awake, if he is encouraged and helped to do this. We have found that many such patients rapidly start to improve. An electrolyte panel should be done, and after increased ventilation is established it may be valuable to use dichlorphenamide. This should be carefully followed with $PACO_2$ examinations and electrolytes since it does produce a transient metabolic acidosis. Since the patient commonly will have cor pulmonale, daily weighing is urgent, digitalization is normally indicated but thiazide diuretics should be avoided since they will worsen the metabolic picture. Adequate potassium must be given and the presence of an elevated potassium in the laboratory is commonly an indication to give potassium since it has been leached from the cells rather than withholding potassium. Should the levels appear to rise alarmingly but the acidosis not worsen dichlorphenamide will solve the problem as a general rule.

SUGGESTED PROTOCOL FOR EVALUATION AND MANAGEMENT OF PATIENTS WITH CHRONIC OBSTRUCTIVE LUNG DISEASE

THE PATIENT WITH SEVERE RESPIRATORY OBSTRUCTION WITH COR PULMONALE AND ACIDOSIS OF A MORE SEVERE LEVEL THAN 65.

These are the patients which should be intubated and put on continuous ventilation with a cycling IPPB device capable of recording the tidal volume which should be monitored. Pressure should be elevated and flow-rate slowed in the case of the patient who simply does not seem to develop tidal volume of above 400 cc on this regime. Continuous monitoring of $PACO_2$ is extremely important. In general, once ventilation has been established, we use dichlorphenamide in these cases, together with steroids and anything else we can think of. Usually double antimicrobial therapy is desirable but Penicillin and Tetracycline together do not have an advantage. We also, in general, withhold Streptomycin because this is an Ace in the hole should a gram negative infection develop. Monitoring of suctioned secretions for bacteriology is urgent and important and should be done more frequently than perhaps one would normally do. There are certain patients in whom a tidal volume sufficient to control CO_2 level cannot be achieved. In these patients intermittent use of succinyl choline is justifiable and need not be accompanied by any sedation. As a general rule, these patients can be rapidly blown off. At this point arterial blood gases are desirable rather than equilibration since almost certainly this patient is not breathing adequately on his own. This is the one situation in which one has to use arterial samples although they may be desirable in other situations as well. Intubation may be kept up under proper supervision for as long as five days, although this is stretching it, but the tube used should have a plastic cuff and should be inflated with an ordinary leur syringe to the point at which just recoils.

In general, all Isuprel by IPPB should be under rigid control since overdosage is so common. We prefer to take the little nebulizer off the IPPB and put a Riker adapter with a medihaler cartridge into the circuit. In this way we know how much the patient gets. Ventricular fibrillation can occur with overdosage.

SUGGESTED PROTOCOL FOR EVALUATION AND MANAGEMENT
OF PATIENTS WITH CHRONIC OBSTRUCTIVE LUNG DISEASE

C. SURGICAL CANDIDATES

The geriatric population has emphasized the need for evaluation pre and postsurgically of pulmonary function and its possible help in the detection of postoperative abnormality. The general rules governing chest and abdominal surgery are that there will be a marked falloff in ability to breathe postoperatively. In general, all patients should have spirography, not necessarily with bronchodilator but simple spirography which if abnormal should be followed up in elective surgical candidates by the standard evaluation procedure as previously outlined. In patients who show marked pulmonary dysfunction certain precautions may well be taken including bronchial toilet, the use of bronchodilators immediate prior and post surgery, especially with intermittent positive pressure breathing devices and during the period between the end of the operation and return to the ward, should inhalation anesthesia be used, a cuffed tube should be left in place until the patient is returned to the room and his ventilation evaluated using the Bennett with the tidal volume meter on it. This is called a monitoring spirometer. Such patients should routinely be put on IPPB with a bronchodilator at least hourly until the period of pain has resolved which may take as long as five days. A $PACO_2$ should be done should the patient show deterioration including changes in sensorium, should it be necessary to use potent analgesic agents, should the patient's original condition have been parlous and should there be a situation in which electrolyte problems might occur. $PACO_2$ should be done within the first 12 hours and any abnormality should be followed up regularly. After full recovery of sensation, a spirogram is worth doing. It acts as a new baseline against pain and should it show further deterioration this would lead one to suspect either atelectasis or abdominal distention was causing further diminution of pulmonary function. Tidal volumes should be done every day using a monitoring spirometer, and this is convenient since such a patient will frequently be using a positive pressure device. Any rise of $PACO_2$ should be treated as a more serious problem than in the nonoperated patient, and this is a situation in which intubation and succinyl choline have had a very great use. Before discharge, pulmonary function should be redone, at least with spirograms, PEV and sputum, hematocrit, etc., although it may not be necessary to do radiologic investigation.

PROBLEMS I HAVE ENCOUNTERED WITH PATIENTS THAT MAY INTEREST YOU

During this very pleasant three days that I have spent, many doctors have talked about specific problems that they have encountered in practice, wondering how we feel about the same problems that we have to deal with too, at the University. We thought it might be interesting just to mention a few of these, perhaps more in general than in specific, and also to take this opportunity to thank you all very much for the very pleasant reception and wonderful time my wife and I have had here.

Antibiotics

The question of length of treatment and type of dosage in the chronic bronchitic or infected asthma patient came up a number of times. We have had most success where following what was discovered in the sputum. We have used relatively short courses of antimicrobials at full dosage. Penicillin and Tetracycline appear to be the primary drugs of choice and we find no reason to go above customary dosage of Tetracycline since the absorption is relatively poor anyway. Penicillin we tend to give in rather larger doses perhaps than most, averaging about 1.4 million a day IM and at least 500 mg q.i.d. one hour before meals. The initial course is usually about a week. We use some Erythromycin but we are impressed that we find so many resistant organisms today to this formerly useful antibiotic and moreover, resistance does develop to Erythromycin relatively early. Chloramphenicol is a magnificent drug and frankly, I think we have been overalarmed by the blood problems. In general, I tend to use 2 grams a day for three days, 1 gram a day for the next three days and then stop and not repeat. Ampicillin I am holding somewhat in reserve, particularly for hemophilus influenzae cases. I think there is a slight tendency to underdose and I use at least 500 mg q.i.d. for the first three days and then, if I feel like it and the patient seems to be responding well, trail off. The same precaution concerning absorption on an empty stomach seems to be quite important in getting good blood levels. I find little use for Lincomycin, and have noticed so much complication in the GI tract. Its narrow spectrum does kind of limit it. The same is true of Novabiocin which I reserve for resistant Staphylococci and also it has rather a high complication rate in terms of hypersensitivity phenomena. Staphylococci in large quantities I usually treat with Penicillin, Methicillin in combination in high dosage (20 million units a day IV) with Keflin and often add Chloromycetin to the regime. I use very little local antibiotic therapy except in a few chronic cases where we have an organism that is only sensitive to something such as Neomycin or Colymycin such as a proteus or a pseudomonas. We have had some luck, however, using Neomycin by nebulizer diluted to 5 grams 25 cc using about 2 to 4 cc a day. I think this is fundamentally rather bad therapy but just occasionally, on a really resistant bacterial bronchitis with secondary organisms, it is very handy. The same is true of Colymycin where one uses 100 mg in 2 cc. Both of these are somewhat irritant and you may have to dilute the dosage further. Streptomycin I hold in reserve absolutely because here is an injectable I can use in fairly large quantities that will specifically knock out gram negative flora which may develop following other therapy. It has the same problem that bacteria learn to live with it too easily and I think that in toto it should be reserved for treatment of either tuberculosis or the complications that one may meet in other kinds of therapy.

PROBLEMS

Bronchodilators

Probably one of the best is Ephedrine and Amytal which comes as a single capsule strength. Interestingly enough the mixture with Phenobarbital which we find in Quadrinal and Tetral is more tolerable than straight Ephedrine because the Ephedrine is broken down more quickly in the liver in the presence of Phenobarbital which has this strange and wonderful property. The Theophylline in these mixtures is absolutely inert, producing no significant blood levels whatsoever. By nebulizer I prefer either Isuprel to anything else. This may be used in combination with Thonzonium bromide in the Medaire nebulizer which produces a more prolonged action. The medihaler duo which contains Neosynephrine has a theoretical objection of rebound but I think this is more theoretical than practical. There is some evidence that a dose lasts longer. I have found no superiority in the other derivatives as yet. Epinephrine, both by injection and by nebulizer, I avoid since it just has too much cardiovascular and psycho effects and its bronchodilator action is no better, if as good, as Isoproterenol. All these agents add to the anxiety of the patient, which brings up the problem of sedation. Where possible we avoid sedation, since we have found, in the more severe cases, that we get untoward depression of respiration by most agents. This means the use of Chloral Hydrate and Paraldehyde just about represents the spectrum of what can be used.

Intubation and Tracheotomy

I think on the whole if one feels that intubation is necessary, it should be done whereas, tracheotomy should be reserved for a less urgent time when it can be done under more ideal circumstances in a patient who is acutely dyspneic, having great trouble with secretions, etc. Following intubation, suction and perhaps positive pressure breathing therapy, it becomes simple to take the patient to the operating room and simply exchange tubes without disturbing the good airway and bronchial drainage that one has established. I feel the metal tracheotomy tubes are really undesirable since they are commonly curved a little but too much and are very irritant to the anterior wall of the trachea if they are to be kept in for any period of time. There are a number of other good tracheotomy tubes made of plastic which are far softer and fit in a more physiologic angle. If worse comes to worse, a rather wide right angle nephrostomy tube cut off near the neck and sewn into the incision does extremely well and also, since it has a cuff, permits the use of intermittent positive pressure breathing. Suctioning through this is a little more difficult because of the rather sharp angle but one soon gets used to that.

IPPB Therapy

I have the feeling that nationwide this is both overused and underused. It is of great usefulness in a person who has problems with secretion who can still cough and relatively occasional treatment ranging from two or three times a day down to a couple of days a week in some chronic bronchitics can help them control their secretions and reduce infection. I think in general we get far too much Isoproterenol during therapy since the little nebulizer simple goes on pushing the stuff out and the patient goes on breathing as it is. I prefer to use an adapter made by Riker which lets you put a medihaler cartridge into the system and dose the patient with the dose you want. IPPB comes into its own when it is necessary to take over a patient's respiration. I think it essential that some form of heated nebulizer be used with this because the gas is dry. Over a long term, if a patient is not

PROBLEMS

IPPB Therapy (continued)

particularly hypoxic, compressed air is usually better than oxygen, since the incidence of patchy alveolar collapse due to absorption of oxygen will be diminished. I think it is important in this context to mention that the average machine on air mix delivers something like 85 to 90% oxygen in use, not the 40% that theoretically it is supposed to. The importance of this is obvious. Generally, in inhalation therapy, I am impressed by the need to provide water, whether by ultrasonic or by heated nebulizer, since in the patient with sticky secretions the use of dry oxygen or air is simply going to dry the patient out more and make the secretions more viscid and hard to get rid of. This goes just as much for intermittent therapy as it does for continued therapy with IPPB.

Corticosteroids

I think the use of corticosteroids has really made a breakthrough in our possibilities of treating some of these chronic wheezing patients. We find a lot of these chronic patients do very well on replacement therapy using 7 1/2 to a maximum of 15 mg a day single dose in the morning Prednisone. They don't appear to get suprarenal atrophy that is so common with massive dosage. On the other hand the allergic component or inflammatory component, whatever it is that further narrows these peoples airways, is diminished. Therapeutic dose is, of course, obvious and we all use about the same kind of regime.

Finally, I want to thank you for a very, very enjoyable time and look forward to meeting you again.

Yours Sincerely,

Roger H. L. Wilson, M.D.

RW:nn

Tulare County General Hospital, Tulare
September 3-5, 1968
Dr. Edwin J. Wylie

C O N F I D E N T I A L

Level of Practice in the Community Hospital

This is a County Hospital, caring primarily for indigent patients. The hospital, until a few years ago, functioned in the traditional manner of County hospitals, whereby the majority of the service functions of the hospitals were provided by volunteers in the medical community. The medical community consists of six to seven relatively small towns of three to twenty thousand in population in a large geographic area with a distance of ten to twenty miles between each town. Because of difficulties in constant attendance by many physicians who found it difficult to leave their distant practices, a full-timestaff at the hospital was recruited. The staff consists for the most part of men retired from general practice or men from other portions of the country wishing a salaried position with less than 24-hour on call responsibility. The most knowledgeable surgeon in this group is a board-qualified younger man in his early twenties, who has had an excellent general and thoracic surgery background. This man's employment is of relatively short duration and was secured at a time where he needed to supplement his financial resources to permit final fellowship training in advanced cardiac and thoracic surgery. It is probably that he will be leaving the Tulare General Hospital within the next few months to seek such a fellowship. There are two additional older men, not board-qualified, who share with the younger surgeon the responsibilities of the surgical cases in the community. The General Medical Clinic is operated by and at the level of the general practice contingent. The Eye and ENT work is done on an on-call basis by qualified men in the community. There are no interns or residents. The level of practice is difficult to gauge with accuracy since I was not called upon to participate in the actual activities of the hospital during my period there. It would be my guess, it is probably slightly below the medium for the usual level of a larger city in the private community.

PHYSICIANS-IN-RESIDENCE Program
Dr. Edwin J. Wylie

Weaknesses

The weaknesses are those that could be anticipated from the recruitment policies of the medical staff. The interests, motivation and medical keeness of the full-time staff, with two or three significant exceptions, are below that of the usual found in private or in larger, strongly disciplined clinics or university atmospheres. The lack of house staff and the relatively small number of men on the senior staff makes it necessary to operate the emergency room by means of paid members of the adjacent medical communities to rotate this responsibility. These men are generally those just beginning practice who require supplementation. These men have no additional responsibilities for following through in the care of patients seen in the emergency room.

Strengths

The recruitment policy has been able to bring in an expert, ambitious radiologist and a young, well qualified surgeon. To the extent that these men contribute to the level of practice, they are a definite plus factor in the level of practice. Nevertheless, it is obvious that once these men become established and known, they will be leaving the hospital for practices in the adjacent communities. The salary level is far below for income in purely private practice and there exists no real educational or service challenge in the structure of the hospital to provide an alternate form of attraction to bring in highly motivated and energetic men.

Areas of Potential Improvement

The administrator of the hospital appears to be a man with a broader background in medicine and in medical administration, than the others on the staff. He is hamstrung however, by factors beyond his control. These consists of first the willingness of the County to provide salaries at a competitive level. The second factor is the physical geography of the area. This is in the center of the agricultural portion of Central California. The climate is hot and arid. Lacking cultural or a stimulating educational enviornment. It will always be difficult to recruit full-time staff members. The construction of a new and modern hospital would in itself create a much more attractive enviornment than is provided by the older structure that is now present. It is likely that a workable compromise could be developed to bring men from a surrounding community, many of whom are board-certified, to participate more actively in the affairs of the hospital. I sensed almost hostility or disdain by those in private practice in the community that attended the lectures. This was not directed toward me or the lecture material but was obvious chasm, social and intellectual, between the outside men and the full-time hospital staff. In the question and answer period that followed each of the lectures the discussion focus was almost entirely between myself and the visiting doctors from the community. The local doctors on the staff, with the exception of Dr. Bifulco and the young temporary surgeon, was noteworthy by its absence. The local staff at the hospital seemed almost to be present only because they had been ordered to do so. The participation of the other men in the community could be done in such a way as to give the community doctors themselves more responsibility in the administration of the hospital.

Problem Areas In The Community

If there are unique problems in this community, it would be difficult to identify them from the brief acquaintance that I had. No opportunity was provided for meeting separately with outside doctors in the community. The doctors on the hospital staff had little knowledge of the level of practice or even of the names of the men on the staff at the various private hospitals in the area. This does remain a traditional general practice area and referral services are available outside this area but within a reasonable distance. Accordingly, for expert consultation or care of patients in complicated problems of cardiac, neurologic, endocrine, vascular, thoracic or other areas requiring medical expertise, patients are referred to a relatively major city, Fresno, approximately 80 miles to the north. The physicians within the community are overloaded. The patient-physician ratio is high for the geographic and intellectual reasons noted above. It appears difficult to attract more physicians to the community. This is the usual national problem of attraction of talent to rural areas and is not any more unique in this rural community than in any other.

The structure of the educational program to be provided by me had been developed in advance by the hospital administrator. This was limited almost entirely to five one-hour lectures. Aside from an extra one hour of reviewing interesting films in the radiologic department, and three or four coffee chats with the director and the young surgeon, there was no contact provided for me with the other men on the staff or with the activities of the hospital.

The attendance of the lectures had been advertised in advance in the various local community hospitals in the adjacent towns. The numbers of doctors attending these lectures from the outside community varied from 15 to 25. This represented perhaps 1/20th of the men in the community who could have profited from the material available in the lecture series. It is noteworthy, however, that the group were present by-in-large represented the most highly motivated men in the area. These men were almost entirely known to me because of previous attendance at postgraduate courses offered locally on the San Francisco campus. The educational material offered could therefore have been as effective from the strictly instructional point of view, if it had been given at the Medical Center.

The foregoing is not meant to imply that there was not a genuine advantage by providing the educational program in the local community at Tulare. It appears highly likely that the willingness of faculty members to travel away from the Medical Center and to live in the local community will fertilize interest in an educational program, since there's clear evidence of the motivation of the faculty in providing this material. I would anticipate that the next two or three speakers will find their attendance much larger than I found. It must be remembered however, that the men attending these lectures must leave a very busy practice to do so. For this reason, any further lectures at any later date should be by men whose reputation locally at stimulating speakers is well established. Lectures should be on subjects that are close to the actual practice problems of doctors in the community, and should be almost entirely clinically oriented. The material should be easily translatable into improvements that each doctor could develop in his own practice. Because of the geographic problem and the wide spread among the communities, it might be well to consider spreading about the activity of the visiting faculty member so that his contacts are not limited to one particular hospital. Those that were genuinely interested could follow him about in the lecture series. To reach a larger number of practicing physicians one could consider evening lectures, one or two perhaps to follow some form of local medical social occasion. The subject matter, or areas of expertise of the visiting faculty man should be advertised in all the hospitals several weeks ahead of the scheduled time of his visit. Some of the men in the local community were unaware of the visit that had been planned for me.

In summary, I think there is great potential for continuation of this program. I would strongly suggest that stimulating speakers of established reputation in various specialities be sent. These men ideally should be closer to the top than the bottom of the departmental structures in which they are working in this Medical Center. I think the program should be spread about the community rather than focused in the small county hospital which appears still to be at some odds with the adjacent community.

SCENIC GENERAL HOSPITAL
830 SCENIC DRIVE
MODESTO, CALIFORNIA 95350

January 21, 1969

Miss Virginia Finley
Continuing Education in Health Sciences
University of California
San Francisco Medical Center
San Francisco, California 94122

Dear Miss Finley:

Due to the fact no one from Scenic General Hospital will be able to attend the evaluation conference on January 25th, I am forwarding the enclosed remarks for your presentation.

I am sorry I am unable to attend the conference and will be anxious to hear from you as to the results of it.

Sincerely,

SCENIC GENERAL HOSPITAL

William A. Todd, Jr., M. D.
Assistant Director of Medical Services

WAT:tf
Encl.

SCENIC GENERAL HOSPITAL....830 Scenic Drive, Modesto, California

MODESTO, county seat of Stanislaus County is situated at the northern tip of the San Joaquin Valley, 93 miles southeast of San Francisco. There are approximately 230 industries in Stanislaus County - about 75% in the Modesto area. Manufacturing is the third largest employing group, following agriculture and trade. The expansion and diversification of industry in the area has seen manufacturing payrolls increase from $15,502,000 in 1950 to $70,500,000 in 1966.

SCENIC GENERAL HOSPITAL is a community hospital, operated by Stanislaus County. 292 licensed beds--189 acute medical-surgical beds. A general hospital offering services in most of the specialties of medicine. There is a General Practice Residency Training Program being alloted 7 spaces--6 are filled--also there is a Surgical Resident from an affiliated program, in 3rd or 4th year of training, rotating at end of 6 months.

Average census past year 149.

Teaching Staff consists of 105 members, all from the county. Except for the G.P.'s Staff members all are either Board eligible or Board qualified.

The emergency and trauma service is exceedingly active, as most of the more serious accident cases arrive here.

A modern and up-to-date Radiology Department is under the supervision of Radiologists of the community--in rotation.

Laboratory facilities are available 24 hours a day (on call basis after normal duty hours). Practically all of the required tests are accomplished locally.

The Medical Libary in the hospital is available to all physicians of the county and receives 51 journals from County Medical Society (108 journals are subscribed to with an active program for updating text and reference books). 3056 volumes.

The speakers, under Physicians-In-Residence program, were well received by those physicians attending.

The program dealing basically with Endocrinology (Dr. Di Raimondo) evoked lively discussion and many pearls were gleaned. These sessions were:

Gynecology Conference (Discussion of Complications of the Pill
Presentation of Endocrine Problems in Gynecological Patients)
Medical and Pediatric Ward Rounds--Discussion on Diabetes
Informal Discussion
Presentation of Problem Cases
Surgical Chest Presentation
Chest Clinic
T. B. Ward Rounds
C.P.C. with discussion by Dr. Di Raimondo
Case Presentation - Retroperitoneal Fibrosis
Case Presentation - Endocrinology Problems--Adrenal and Pituitary
Endocrine Problem Cases

The attendance included physicians from all phases of medicine although the numbers were relatively small, those who attended were rewarded for their effort.

The program by Dr. Blacker:

Discussion of the mechanics of commitments followed by ward rounds
Lecture on Community Health Centers
Consultations in Child Psychiatry
Discussion of Hypnosis in General Practice
Individual interviews
Lecture in Group Therapy
Consultations with local practitioners
Lecture--Use and Abuse of Tranquilizers

This program had a narrower field of appeal to the physicians but again, those who attended were enthusiastic and much lively discussion was generated. This program was particularly beneficial to the house staff, especially in the approach to the so called "crock" with psychosomatic manifestations.

The various specialty groups in the community are actively pursuing some form of continuing education. We are very fortunate to be close to a wealth of educational material and these programs are being taken advantage of. As with any community, time has become a precious item and to attract large numbers of doctors, during the week is not easily accomplished. Many feel they can pick a program and get more from it away from home as they are not confronted with frequent calls.

The house staff cannot get away as freely and they can not be exposed to too many programs of this nature.

SAN JOAQUIN COUNTY CALIFORNIA

SAN JOAQUIN GENERAL HOSPITAL
P. O. BOX 1020
STOCKTON, CALIFORNIA 95201

LOUIS M. BARBER, M. D.
ADMINISTRATOR

ROBERT W. BRISSENDEN
ASST. ADMINISTRATOR

January 6, 1969

Seymour M. Farber, M.D.
Dean of Educational Services
and Director of Continuing Education
Health Sciences
University of California
San Francisco Medical Center
San Francisco, California 94122

Dear Dr. Farber:

I regret being unable to attend the meeting January 25, and although I have taken the matter up with our Education Committee, it seems that the other physicians find themselves in a similar bind.

In lieu of a representative, we have decided to send our comments, which can be read to the group.

From my own standpoint, I have been quite pleased with the overall results of the three meetings we have had. It is obvious to me that the logical place to continue medical education for our community physicians is at San Joaquin General Hospital, but because of certain local factors, this has been extremely unsuccessful. The physicians in the community will not come to this hospital and, therefore, another approach is needed. The only approach I can see feasible is the one used for these three meetings. We certainly would have appreciated much better attendance, but half a loaf is better than no loaf at all, and a group of interested physicians was on hand to listen to each of the speakers at each session. The size of the groups varied, but I personally believe that the money spent by the government for the purpose of this program was no doubt the best spent money the Federal Government used this last year. Furthermore, since this approach is the only reasonable approach to continuing education that I have run across, I heartily endorse it and regret the program has come to a close. It would be my considered recommendation that this approach to community physicians' education be continued and developed.

The only real solution to continuing education is for the physician to take so many months off each year and reenter a medical center training program as a preceptor in his chosen area of work. This has not been feasible except in rare instances under the present setup. It has been suggested by Dr. Saul Robinson in a recent editorial in the CMA Journal that the physicians be subsidized for these training efforts. I would agree with Dr. Robinson that this may be a reasonable approach and would seem to be a potentially valuable area to investigate.

The millions of dollars available through our regional medical programs can only be effective if used in the continuing education of the physicians and paramedical personnel. At present there seem few other avenues of approach to the solution of this problem.

I hope the above comments will help. I am as frustrated in this area as anyone and hope some useful results come out of the meeting.

Sincerely yours,

JDBernard

J. David Bernard, M.D.
Chairman
Continuing Education Committee
San Joaquin County Medical Society

JDB:ml

P.S. I have enclosed similar letters from the chairmen of the various meetings.

GEORGE K. WEVER, M.D.
VIRGIL J. GIANELLI, M.D.
ROBERT F. NEJEDLY, M.D.
JAMES S. GODWIN, M.D.
1805 NORTH CALIFORNIA STREET
STOCKTON, CALIFORNIA 95204

January 1, 1969

J. David Bernard, M.D., Chairman
Continuing Education Committee
San Joaquin County Medical Society
445 West Acacia Street
Stockton, California

Dear Dr. Bernard:

On December 18 and 19, 1968 Dr. Peter Forsham conducted a Professor in Residence program at St. Joseph's Hospital and San Joaquin General Hospital. The topics covered various aspects of diagnosis, treatment and pathophysiology of endocrin disorders. Participation by the members of the medical staff at St. Joseph's Hospital and the Residence-Intern staff of the San Joaquin General Hospital was excellent.

This type of program, in my estimation, is one which provided us with a maximum amount of useful information in the minimum amount of time expended. Comments from the doctors attending seconded this impression.

There was general disappointment expressed when it was learned that this program is to be discontinued. Some suggested that the medical society investigate means of funding such a program locally and that an attempt be made to work out some format in which the university would provide us with teachers necessary for such an undertaking.

May I express my thanks to you for your help in making this program such a success.

Sincerely yours,

R. F. Nejedly, M.D.

Robert F. Nejedly, M.D.

RFN:jlp

DAMERON HOSPITAL
1049 NORTH LINCOLN STREET
STOCKTON, CALIFORNIA
95203

December 23, 1968

J. David Bernard, M.D.
San Joaquin General Hospital
French Camp, California

Dear Dr. Bernard:

The Professor in Residence program, sponsored by the University of California Continuing Education Committee, took place on Thursday, Friday and Saturday, September 19, 20 and 21, 1968 with the presence of Dr Victor Richards and was sponsored by the Surgical Department of Dameron Hospital.

The presence of Dr. Richards in Stockton for those two and one half days, cannot be classified in any other way but a complete success. Dr. Richards' broad knowledge, easygoing manner and cooperation was the single most important factor in this success. Participation from the speciality groups, as well as from general practicioners, was excellent. The sessions were extremely well attended, with never less than about 50 physicians present. The format used was well received. It consisted of subjects of broad interest, introduced by one of the local physicians, with an opportunity for Dr. Richards to speak on the problem and ample time for question and answer periods. Presentations of difficult cases of broad interest was likewise well received, as was the final pathology session on Saturday morning. It is hoped that the University of California will be able to continue the program since it reached many of the physicians who might not otherwise take the time to attend out of town meetings.

Sincerely yours,

G de L'Arbre

G. de L'Arbre, M.D.
Chairman, Department of Surgery
Dameron Hospital

GD/bc

January 21, 1969

Seymour M. Farber, M.D.
Dean of Educational Services and
Director of Continuing Education
University of California
San Francisco Medical Center
San Francisco, California 94122

Dear Doctor Farber:

I am sorry I shall be unable to attend the critique January 25, 1969. A previously scheduled Regional Medical Planning meeting involving faculty members from the University of Southern California Medical School make it impossible. I hope this written report will reflect in some small way the reaction of our medical community to the recent visit of Dr. Kenneth L. Melmon.

San Luis Obispo is a city of approximately 25,000, the county seat of San Luis Obispo, The main source of income in this area is agriculture and tourism, the latter being confined chiefly to the summer months.

San Luis Obispo General Hospital is a 206 bed hospital of which 140 beds are utilized in the treatment of acute medical, surgical and psychiatric cases. The hospital provides the only psychiatric facilities available within the county. This consists of a Community Mental Health Program providing an outpatient department, twenty-six inpatient beds and composed of a staff of two psychiatrists, a general practitioner, three nurses and eight psychiatric social workers. The remainder of the beds are divided between medicine, surgery and a small pediatric and obstetrical department. The medical and surgical wards contain approximately forty beds apiece. The non psychiatric portion of the hospital is staffed by two general practitioners. In addition to the full time county employees, we have a medical staff of fifty-four active members who are in private practice in the area.

The attending staff at the San Luis Obispo General Hospital is composed primarily of specialists, all major specialties being represented by from three to five practitioners. Approximately twelve men on the staff are engaged in general practice.

Because of the high proportion of specialists within this rather small group, we entered into the Physician in Residence Program with some misgivings, not to say skepticism. We felt it would be most difficult to find an area of common interests for such diverse specialists as ophthalmoligists, psychiatrists, dermatologists and oral surgeons; however, through either a great stroke of good fortune or keen foresight on the people assigning physicians, Dr. Kenneth L. Melmon, Chief Division of Clinical Pharmacology, University of California, San Francisco, was assigned as our physician in residence.

Due to my lack of experience in arranging this program, Dr. Melmon's presentations were confined to four lectures presented at the hospital as breakfast and luncheon meetings, January 6 and 7, 1969. Seventeen physicians attended the initial breakfast lecture. Twenty were present that noon. Fifteen attended the breakfast lecture the following morning and forty-two attended the luncheon meeting. Although, the subject matter of the final lecture may have had more general interest than those previously presented, I feel word of mouth reports of Dr. Melmon's meetings led to the large attendance at the final meeting.

In an effort to assess the effect of this series on the staff, I sent out a questionnaire concerning attendance, value of the meetings, interest in further meetings and suggestions for change in format. I was gratified by receiving approximately a 90% response to my questionnaire. In all but two instances comments on the program were most favorable. The physicians stated they would be most anxious to continue the series and several suggestions concerning subjects for further sessions were made. I might add the physicians finding fault with the program have been known to question motherhood, pure milk, and the American way of life.

In summary, I feel that the Physician in Residence Program in San Luis Obispo General Hospital was a success. I feel that future meetings would be even more successful inasmuch as we will be prepared to work out a format that effectively utilizes the skills of the visiting physician.

Yours truly,

Richard L. Anderegg, M.D.
Director of Medical Services

RLA:sw

cc: Dr. Kenneth L. Melmon
Dr. L. Don Kimbrough

PATHOLOGIST

ADMINISTRATIVE OFFICE
VISALIA, CALIFORNIA
P. O. BOX 3128
PHONE 732-7926

EXETER MEMORIAL HOSPITAL
EXETER, CALIFORNIA
215 CRESPI ST.
PHONE 592-2151

TULARE, CALIFORNIA
869 N. CHERRY ST.
PHONE 686-6783

February 14, 1969

[illegible]
EDUCATION

1969 FEB 17 AM 8 55

Roger H. L. Wilson, M. D.
Associate Director
Continuing Education and Health Sciences
University of California
San Francisco Medical Center
San Francisco, California 94122

Dear Roger:

Hurry - Hurry! We have a tiger by the tail. Events have moved swiftly and climactically. Although partially disorganized the Tulare County Council of Hospital Administrators (to whom I spoke as a group) overwhelmingly endorsed continuing the program and pledged financial support. We have an embarrassment of riches. One hospital committed $600 and the staff matched the amount. Total concrete pledges including Dr. Hayes and I, are now in the neighborhood of $2000. The real problem is to prorate the consultant and money equitably, but this is mechanics.

I must confess my brave committments of money in San Francisco were somewhat groundless. Not one schilling had been pledged but a little salesmanship overcame that deficit.

Hospitals in Kings County (adjacent to us) now want to participate and they will communicate with us.

Please call collect area code 209-734-0465 if you are able to have something positive for programming by February 20. This is the next meeting of the program committee.

Best personal regards,

Jim

James A. Sargent, M. D.
Pathologist

JAS/pb

(Dr. Vincent di Raimondo has accepted RW)

FRANK H. DAILEY, M. D.
719 SO. DORA STREET
UKIAH, CALIFORNIA 95482

TELEPHONE 462-8893

January 21, 1969

Seymour M. Farber, M.D.
Dean of Educational Services and
Director of Continuing Education in
Health Sciences
University of California Medical Center
San Francisco, California

Dear Dr. Farber:

I am sorry that I am unable to attend the evaluation conference on Saturday, January 25, 1969 because of a previous commitment. It is also impossible for the other physicians in our area, who have helped plan the program, to attend. I would like to take this opportunity however, to express the opinions in our area to date relative to the visiting professor program.

Your letter of January 16, 1969 suggested six topics of interest and I will follow this format.

1. General description of Community.
   Ukiah, California is a city of approximately 10,000 people with a nearby surrounding population of perhaps another 20,000. The industry is largely agricultural and lumber, although recreation and tourist trade also is important here. A large part of the economy is based on Mendocino State Hospital with a large employment.

2. A general description of hospital facilities and staff.
   In Ukiah there are two 45 bed hospitals, one privately owned and one a non-profit corporation. There is also a County Hospital which is now a community hospital with approximately 50 acute and 50 chronic beds and also nearby is Mendocino State Hospital with approximately 1800 beds. There are approximately 12 general practioners and 15 specialists in Ukiah, 3 general practioners in Willits, 30 miles to the north, 5 or 6 general practioners in Fort Bragg and in neighboring Lake County approximately 15 general practioners and no specialists. The specialists in Ukiah represent a wide variety of specialization, most specialists are in the younger age group and all have received their Specialty Boards.

3. Attitudes of physicians towards Continuing Education.
   Most of the physicians in Ukiah are actively continuing their education by attendance of Medical meetings on the average of three or four times a year. In addition to this we have our monthly hospital professional programs at each of the private

FRANK H. DAILEY, M. D.
719 SO. DORA STREET
UKIAH, CALIFORNIA 95482

TELEPHONE 462-8893

January 21,1969

hospitals, County Medical Meetings with outside speakers three times a year and in Ukiah a two hour weekly professional meeting which is very well attended by specialists and regularly attended by several practioners.

4. Reactions of physicians attending sessions.
Physicians who attended the two sessions we have had to date were quite pleased with the organization and format of the sessions and felt that practical information of immediate usefulness was gained.

Dr. John Gamble and Dr. Frank Leeds were the two visiting professors. Each session consisted of three half day programs. Topics were planned in advance and consisted of case presentations, illustrating difficult practical problems in the field of gastroenterology with Dr. Gamble and in the field of vascular disease with Dr. Leeds. The local physicians prepared their cases well, gave precise presentations and this was followed by discussion of the case and of the topic by the visiting professor and then by question and answer periods.

In the evening a dinner party in one of the physicians' home was given for each professor and was well attended by local physicians. The several hours spent in this informal way was also quite helpful in discussing many other related medical problems as well as problems relating to medical education.

5. Appraisals of accomplishments of the program.
In addition to the information gained directly from the program we feel, and hope that the visiting professors feel, that we are establishing a closer relationship between the physicians of this area and physicians in the University environment. We believe in this way that we can gain a great deal from the educational standpoint and that members of the University Staff will gain a great deal of understanding of the level of medical care rendered and the types of problems existing in our area. We feel that in the past there has perhaps been a feeling among physicians in larger cities and in the University in particular that the quality of medical care in the small country community is of a rather inferior grade. We are pleased to be able to demonstrate through our cooperation with this program and first-hand presentation and demonstration of case material, that quality of care ~~and~~ in our area is of a high level and that the types of educational programs to be presented to smaller communities should also be of a high level.

FRANK H. DAILEY, M. D.
719 SO. DORA STREET
UKIAH, CALIFORNIA 95482

TELEPHONE 462-8893

January 21, 1969

6. Appraisals of the needs of the physicians in the area. Physicians in the smaller community more than 100 miles from the University needs some sort of regular access to frequent University conferences and meetings, such as Medical Grand Rounds, guest lectures, surgical rounds, C. P. C's et cetera. We live too far for the average physician to be able to drive back and forth for weekly Grand Rounds et cetera. Undoubtedly, a program of close circuit T.V. would be the greatest advance in post-graduate medical education that could be achieved at the present time. The weekly radio conferences have not fulfilled their desired goal in this community. They come at a time in the middle of the day when it is difficult for physicians to attend. The radio reception has often been poor. The topics are frequently not of general interest. In the hospital environment there are frequent interuptions to those who are trying to listen to the programs.

I am certain from speaking to physicians repeatedly about post-graduate education that close circuit television programs would be extremely well and regularly attended by our physicians.

Sincerely,

FHDailey MD

Frank H. Dailey, M.D.
Chairman- Post Graduate
Educational Committee
Mendocino-Lake County Medical
Society.